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AUTHOR Geizer, Bernard P., Ed.
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ABSTRACT

The report presents the results of an evaluation of New York's 13 Alcoholism Treatment Centers (ATCs). The goals of the evaluation were to review the role of the ATCs in relation to other alcoholism treatment facilities, to assess their effectiveness and efficiency, and to determine how much money is collected for service provided to patients. Following the executive summary, the introduction briefly defines and provides data on the incidence of alcoholism, and describes the goals of the ACTs and their organization. Chapter II provides: a description of the ACTs' service areas, with data on patient characteristics, and occupancy rates by service type (detoxification, rehabilitation, communtiy living); descriptions of program responses to poly-drug users, treatment rationale and methods, and program plans for state, county, and city services; and findings of a study of the effectiveness of the ACTs. Chapter III reviews the scope and results of monitoring of ACTs by the Joint Commission on Accreditation of Hospitals (JCAH) and by the New York State Division of Alcohol Abuse and Alcoholism. Chapter IV reviews the costs, staffing, of revenues of the ACTs. The appendices include a list of those interviewed and contacted for the evaluation, and copies of the correspondence between the agencies involved in the evaluation. (MCF)

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LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW
111 WASHINGTON AVENUE — ALBANY, NEW YORK 12210
518-474-1474

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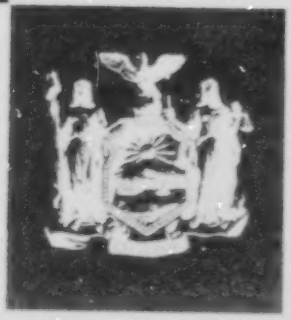
State Alcoholism Treatment Centers



Program Audit
December 1983

SUMMARY AND CONCLUSIONS

The New York State Division of Alcoholism and Alcohol Abuse (DAAA) estimates that in 1980 there were 1,191,262 problem drinkers in New York State, of whom about half had become addicted to alcohol. Alcoholism may result in disruption of families and loss of employment. In its advanced stages it causes shakes, delirium tremens, and alcohol related medical problems such as cirrhosis and hepatitis.

DAAA operates 13 State alcoholism treatment centers with 560 beds. These include 48 used for detoxification, 493 for rehabilitation, and 19 for independent living. They are located in State psychiatric centers across the State. This program audit reviews the role of these State alcoholism treatment centers (ATCs) in relation to other alcoholism treatment facilities and organizations, assesses their effectiveness and efficiency, and determines how much has been collected for services to patients.

Role of the Centers

The principal role of the 13 State alcoholism treatment centers is to rehabilitate alcoholics who have been detoxified or sobered up and make them totally abstinent, according to the directors of the ATCs. DAAA stated in a letter of October 27, 1983 to LCER that "The principal role of the 13 State alcoholism treatment centers is to provide to alcoholics who have been detoxified or sobered-up repeatedly, the inpatient rehabilitation component of the continuum of care which is required toward their ultimate sobriety." Usually four to six weeks are spent in rehabilitation as an inpatient.

Admissions

The patients at the State alcoholism treatment centers are admitted on an informal basis and are free to leave the program at any time. However, a person will have a strong incentive to stay in the program if he or she has had his or her driver's license suspended or revoked, pending rehabilitation from alcoholism.

In 1982-83 there were 6,714 admissions to the State alcoholism treatment centers. This is about one percent of the estimated number of alcoholics in New York State. The principal sources of patients at ATC rehabilitation units are detoxification services and sobering-up stations. Central Islip, Rockland and St. Lawrence ATCs are the three ATCs with their own detoxification services. Twenty eight percent of those admitted to these detoxification units opted to enter rehabilitation. Of all admissions to these three ATCs' rehabilitation units, 60 percent had first been through the ATC's own detoxification services. Sobering-up stations in New York City indicated that about four percent of the people they assist go to a State alcoholism treatment center. The others return to the street, to home, to social services, to out-patient services and to community agencies such as the Salvation Army. Those who are referred to State centers generally must be well motivated to want to commit themselves for four to six weeks to a recovery program.

The principal admission requirements to rehabilitation that the State centers have are:

--18 years or older except with parental consent or emancipated minor status,

--Free of addictive drugs,

--Dependent on alcohol but detoxified from alcohol from one to seven days, and

--Free from active psychosis or severe mental retardation.

Each center has its own admission policy and there are exceptions to the above four requirements. Eight of the ATCs do not admit anyone actively using drugs of any kind but will admit patients who have had a record of drug abuse. Pilgrim ATC will admit persons using marijuana, cocaine, amphetamines, or LSD. Buffalo, Marcy and Rockland ATCs will treat those using Valium or other minor tranquilizers, amphetamines, or marijuana. The Rochester ATC will admit patients with both an alcohol abuse and a drug abuse problem. It is the only ATC to accept an alcoholic patient into rehabilitation who was on methadone maintenance which is the main method of treatment funded by the New York State Division of Substance Abuse Services to combat heroin addiction. The other ATCs will not accept methadone patients in rehabilitation primarily because they regard its continued use as inconsistent with trying to get patients off alcohol. They regard both alcohol and methadone as "mind altering" drugs.

When a patient admitted to a psychiatric center has a diagnosis of alcohol abuse/alcoholism in addition to psychiatric problems, ATC staff are available for patient assessments and treatment recommendation. The Kingsboro ATC makes a special effort to treat the psychiatric alcoholic.

However, in general, the policies of the ATCs do not permit admission of persons with dual addiction to alcohol and hard drugs or those with addiction to alcohol who are psychotic. However, the Mental Hygiene Law states that "no person shall be denied treatment and services because he suffers from more than one disability." The ATCs' admission policies do not sufficiently conform to that requirement.

Treatment

Persons in rehabilitation at the State ATCs receive medical care, individual and group therapy, alcoholism education, psychiatric services, family education and counseling, activities therapy, vocational counseling and introduction to Alcoholics Anonymous. The taking of the drug, disulfiram, is required by the Creedmoor ATC and its use is forbidden by the Middletown ATC on the ground that it is potentially dangerous. The St. Lawrence ATC permits its use on rare occasions. The other ATCs permit or encourage its use. Its purpose is to prevent impulsive drinking because its use in combination with alcohol causes throbbing, respiratory difficulty and nausea. The Manhattan ATC, which formerly required its use, no longer does because it was said to be the cause of five seizures. DAAA, which has no overall policy on its use, is studying whether disulfiram has caused seizures at other ATCs.

DAAA has an agreement with the State Office of Vocational Rehabilitation (OVR) whereby OVR would provide vocational rehabilitation services to patients in the ATCs. However, because OVR requires that patients be abstinent for six months, virtually no OVR services are received at the centers. While exceptions may be made to this six months requirement, ATC directors expressed dissatisfaction with the lack of OVR services.

DAAA Policy

In December 1982, DAAA published Systemwide Program Plans for State Operated Alcoholism Services. Principally this called for:

--Transfer of the three detoxification services at Pilgrim, Rockland, and St. Lawrence ATCs to general hospitals in 1982-83 or 1983-84. This involves 48 ATC beds. As of August 1983 none of these transfers had occurred.

--An increase of 50 beds at the ATCs for rehabilitation purposes from 498 to 548.

This increase is contingent on the transfer of the detoxification beds and as of August 1983 had not occurred.

--With regard to rehabilitation services an increase in occupancy rates from 82 percent in 1981-82; to 86 percent in 1982-83; to 90 percent in 1983-84. DAAA did reach an 86 percent occupancy rate in 1982-83. DAAA reduced length of stay and increased occupancy rates to serve more patients.

DAAA estimates that there is a shortage of 1,575 rehabilitation beds in New York State. There have been 647 additional ones proposed which would still leave a shortage of 928 according to DAAA's analysis of bed need. However, DAAA qualifies its estimates of bed needs by saying that as more programs become available, service utilization patterns must be studied.

Effectiveness

The goal of each ATC according to the ATCs is to have a patient totally abstinent from alcohol. DAAA stated to LCER on October 27, 1983 that "The goal of each ATC with respect to patient abstinence is to provide an intensive treatment experience which forms the base for long term sobriety. Complete recovery for most alcoholics frequently occurs after several relapses." LCER asked each ATC to indicate how many of their former patients released within the past year had remained abstinent for one year after discharge. Only the Bronx and St. Lawrence ATCs had records adequate to show what had happened to their patients, during the prior year.

One year after discharge from rehabilitation, at St. Lawrence, out of 133 patients discharged to aftercare 46 (35 percent) were abstinent. At the Bronx ATC out of 80 patients who completed treatment, after one year, 16 were abstinent, five were not, and 59 could not be traced.

The follow-up of patients in community facilities is made more difficult because DAAA does not require community agencies, usually funded by the State, to report on what happens to individual patients discharged from the ATCs with referrals to such agencies. The community agencies raise the issue of confidentiality of patient records. However, DAAA abides by State and federal regulations when treating patients in its own facilities and could do so with community agency records.

The Research Institute on Alcoholism, which is part of DAAA, conducted a two year study of outcomes of 1,340 clients released from ATCs from 1976 to 1978. Five years have elapsed and the results can not be applied to the present ATCs because of changes in treatment, length of stay, and ATC personnel. Nothing has been done since 1978 on ATC treatment effectiveness by the Research Institute.

Efficiency

To be efficient, DAAA should be successfully treating the greatest number of persons possible at the lowest reasonable cost.

The utilization of beds for the three services in the State alcoholism treatment centers in 1982-83 was:

		Percent Occupied 1982-83	
			DAAA
Alcoholism Service	Beds	Actual	Goal
Independent Living	19	47	90
Detoxification	48	67	90
Rehabilitation	493	86	86

Less than half of the independent living beds at Central Islip were occupied in 1982-83 compared with DAAA's goal of 90 percent. The 48 detoxification beds at Central Islip, Rockland and St. Lawrence were also underutilized at 67 percent. Underutilization of independent living and detoxification beds could be solved if the transfer of these services to community providers is accomplished as planned by

DAAA. This requires the cooperation of four general hospitals and the State Health Department to transfer the detoxification services and the cooperation of Suffolk County to transfer the independent living unit.

The 493 rehabilitation beds were utilized at 86 percent of capacity, the DAAA goal. The least utilized was Central Islip at 54 percent, while Rockland was run at 116 percent of capacity. The other 11 centers ranged from 82 to 96 percent occupancy (Table S-1).

The rehabilitation service per patient day costs for 1981-82 ranged from $54 at Rockland to $173 at South Beach. The costs were higher in those centers with the least number of patient days. Because of wide variation in length of stay and cost per patient day at the ATCs, the cost per stay for rehabilitation patients varied from $1,847 at Rockland where the length of stay was 34 days to $8,167 at Bronx where the length of stay was 54 days.

Until DAAA knows more about how long a person should be kept in treatment to achieve maximum success in staying abstinent, it is not possible to say what cost per stay was most efficient.

The total costs of the centers were $19.6 million in 1981-82 including rehabilitation and independent living--$16.2 million, detoxification--$2.8 million and outpatient services--$534,000.

Monitoring

All 13 ATCs are certified by the Joint Commission on Accreditation of Hospitals (JCAH) which inspects them at one, two, or three year intervals. DAAA performs a

Table S-1

Rehabilitation Services at
State Alcoholism Treatment Centers
1982-83

Center	Beds	Admissions	Patient Days	Percent Occupancy	Average Length of Stay (Days)
Bronx	24	156	8,356	95	55
Buffalo	30	389	10,538	96	27
Central Islip	79	414	15,416	54	37
Creedmoor	24	182	8,039	92	44
Kingsboro	27	149	9,176	93	62
Manhattan	60	602	19,700	90	33
Marcy	60	540	20,538	94	38
Middletown	27	223	9,028	92	42
Rochester	40	295	11,922	82	37
Rockland	31	391	13,078	116	33
St. Lawrence	36	298	10,742	82	37
South Beach	25	238	8,270	91	36
Willard	30	286	10,316	94	36
Total	493	4,283	155,119	86	40

Source: DAAA, Local Services Statistical Reporting System (LS-2C), July 13, 1983.

pre-JCAH inspection of its own and tries to correct any deficiencies before JCAH inspectors arrive. DAAA in 1982 conducted site visits at each of the 13 ATCs using its own staff to review client records, staff training, planning and evaluation, continuity of care, and community relations.

DAAA sets standards for and inspects and certifies community agencies which serve alcoholics. The Mental Hygiene Law exempts State facilities from certification but does empower DAAA to set standards applicable to any facility providing services to alcoholics including State-operated facilities. However DAAA has not established uniform standards applicable to itself and community agencies. As a result State ATCs are not required to meet such standards as annual fiscal audits and adherence to bed capacity limits that cover community agencies.

Collections

The Office of Mental Health (OMH) collects funds from Medicaid, Medicare and third parties on behalf of patients at the State alcoholism treatment centers. From April 1, 1983 to May 30, 1983, OMH collected $85,409 for alcoholism patients. At this rate OMH will collect less than three percent of what it costs to operate the centers in 1983-84. The estimated $512,000 to be collected in 1983-84 compares to $2.8 million estimated in the 1983-84 Executive Budget. Since June 1982 the federal government has not paid Medicaid claims for either alcoholism or psychiatric patients ages 21-64. This decision of the federal government is now the subject of negotiation between the State and federal governments. In addition, from July 15, 1981 to May 28, 1983 the federal government did not pay any Medicaid or Medicare claims filed by OMH for either psychiatric or alcoholic patients at Manhattan Psychiatric Center. While the Manhattan Alcoholism Treatment Center had JCAH accreditation, the Manhattan Psychiatric Center in which the ATC is housed, lost its JCAH accreditation during this period. Both accreditations, are required for the State to be paid by the federal government for Medicaid and Medicare patients.

Conclusion

Rehabilitation of alcoholics in a four to six week inpatient program is the main goal of DAAA's alcoholism treatment program. It is the middle step in the whole treatment process. It occurs after a person has been detoxified from alcohol or sobered up. It should be followed by an outpatient program or some self-help program such as Alcoholics Anonymous.

DAAA records at 11 of 13 alcoholism treatment centers do not show with any authority how effective the treatment is in keeping people abstinent after they complete treatment. DAAA in a letter of October 27, 1983 stated that abstinence was only "one measure of effectiveness." Records at St. Lawrence show that 35 percent of the persons who completed treatment were still abstinent after being out one year. At Bronx 59 out of 80 patients completing treatment could not be located after one year.

It could not be resolved from DAAA records what should be the optimum length of stay at a State alcoholism treatment center to achieve sustained abstinence.

The centers generally admit alcoholics who are motivated to become abstinent and have no major medical or drug abuse problem or active psychosis. With the exception of the Rochester ATC they will not accept an alcoholic into rehabilitation who is also abusing hard drugs or is on methadone maintenance. The Mental Hygiene Law requires that persons with multiple disabilities should not be denied treatment.

All 13 ATCs are certified by the Joint Commission on Accreditation of Hospitals. DAAA does not apply or enforce at these centers the same standards it requires of community alcoholism services.

The detoxification services of three State alcoholism treatment centers providing it

are underutilized. DAAA would like to transfer the three ATC detoxification services to general hospitals.

The collections made by the Office of Mental Health for patients in State alcoholism treatment centers in the first two months of 1983-84 were $85,409 and if revenues are projected for the full fiscal year will amount to less than three percent of what it costs to operate the centers.

On June 29, 1983, DAAA had 70 executives and specialists in alcoholism paid over $30,000 annually in its main and regional offices. Despite this fact, DAAA, while establishing policy in such areas as number of admissions, occupancy rates and length of stay, has allowed the alcoholism treatment centers to pursue their own ways without definitive policy guidance on such important matters as use of disulfiram, admission or non-admission of multiply disabled persons, and types of follow up to be conducted of patients released from the ATCs. The result of lack of policy direction is that there is no assurance that the treatments being carried out are effective in keeping people abstinent.

Findings for Comment

Chapter 58 of the Laws of 1980 requires heads of audited agencies to report within 180 days of receipt of the final program audit to the Chairman of the Legislative Commission on Expenditure Review and the Chairmen and the Ranking Minority Members of the Senate Finance Committee and the Assembly Ways and Means Committee on what steps have been taken in response to findings and where no steps were taken, the reason why.

State Division of Alcoholism and Alcohol Abuse

1. The Mental Hygiene Law requires that no person be denied treatment and services because he or she suffers from more than one disability. Most ATC admission policies on multi-abusers of alcohol and hard drugs do not sufficiently conform to the law. (See p. 41.)

2. Although the dangerous side effects of the drug, disulfiram, have been docu-

mented at Manhattan ATC, DAAA has no overall policy governing the use of disulfiram in State ATCs. (See p. 41.)

3. As of August 1983, detoxification services were being provided to alcoholics at Pilgrim, St. Lawrence and Rockland ATCs although it is a goal of DAAA to transfer this service to local sponsorship. General hospitals have been identified for all three detoxification units but transfers are pending the submission and approval of Department of Health Article 28 applications or establishment of scatter bed services at two hospitals. (See p. 42.)

4. The follow-up data on patients released from ATCs other than Bronx and St. Lawrence are inadequate to judge how the patients fared after leaving the centers. (See p. 42.)

5. While DAAA has its own fiscal field auditors, they have not audited the State alcoholism treatment centers. (See p. 47.)

6. DAAA has not applied to its own alcoholism treatment centers all operating standards applicable to non-DAAA alcoholism treatment facilities. (See p. 47.)

7. Neither the OMH nor the DAAA management information system is capable of telling whether a patient discharged from a State alcoholism treatment center reports for and receives service from the community agency to which he or she is referred. (See p. 47.)

State Office of Mental Health

8. Based on two months collections from April 1, 1983 to May 30, 1983 of $85,409 projected to a full year, OMH will recover less than three percent of costs of operating the State alcoholism treatment centers in 1983-84. If projected to March 31, 1984 this would be approximately $512,000 compared to $2.8 million estimated in the 1983-84 Executive Budget. (See p. 51.)

State Office of Vocational Rehabilitation

9. Most of the State ATCs were dissatisfied with the Office of Vocational Rehabilitation services to recovered alcoholics due to OVR's eligibility requirement that alcoholic clients be abstinent for six months prior to receiving OVR services. (See p. 42.)

ABBREVIATIONS AND GLOSSARY

Abbreviations

AA - Alcoholics Anonymous.

ATC - Alcoholism Treatment Center operated by DAAA.

DAAA - New York State Division of Alcoholism and Alcohol Abuse.

DSAS - New York State Division of Substance Abuse Services.

IOCC - Inter-Office Coordinating Council.

JCAH - Joint Commission on Accreditation of Hospitals.

LCER - New York State Legislative Commission on Expenditure Review.

OMH - New York State Office of Mental Health.

OMRDD - New York State Office of Mental Retardation and Developmental Disabilities.

Glossary

Cirrhosis - A disease especially of the liver with hardening caused by excessive formation of connective tissue followed by contraction.

Community Living - (also called "independent living") - A special program formerly at Central Islip ATC now at Pilgrim ATC for persons who have completed rehabilitation, work in the community, and live at the ATC.

Detoxification - A means of removing alcohol from the system under medical supervision.

Halfway House - A residence in the community where recovering alcoholics live following rehabilitation.

Hepatitis - Inflammation of the liver.

Problem Drinker - Heavy escape drinker who may or may not be an alcoholic.

Rehabilitation - An inpatient program to serve persons who wish to become abstinent from alcohol.

Sobering-Up Station - A residential facility where persons may sober up. Medical personnel may include nurses. A back-up hospital is available for emergencies.

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FOREWORD

The Legislative Commission on Expenditure Review was established by Chapter 176 of the Laws of 1969 as a permanent legislative agency for among other duties, "the purpose of determining whether any such department or agency has efficiently and effectively expended funds appropriated by the Legislature for specific programs and whether such departments or agencies have failed to fulfill the legislative intent, purpose and authorization," and to "make a comprehensive and continuing study of . . . the program of and expenditures by state departments." This program audit, State Alcoholism Treatment Centers, is the one-hundred and twelfth staff report.

The audit reviews the role of the 13 State alcoholism treatment centers in relation to other alcoholism treatment services and assesses their effectiveness and efficiency. Patients at the 13 centers normally stay four to six weeks. Total abstinence from alcohol is the goal. Two of the centers, Bronx and St. Lawrence, do extensive follow-up studies of their discharged patients. The follow-up data on patients released from the other 11 alcoholism treatment centers were inadequate to judge how the patients fared after leaving the centers. More comprehensive and consistent follow-up studies and experimental programs would give a better basis for deciding how long a patient should stay in inpatient rehabilitation. The alcoholism treatment centers cost $19.6 million to operate in 1981-82. Policy direction from the Division of Alcoholism and Alcohol Abuse in the key areas of disulfiram use, follow-up, and treatment of the multiply handicapped was lacking.

Appreciation is expressed to the personnel of the Division of Alcoholism and Alcohol Abuse, the Office of Mental Health, and the Office of Vocational Rehabilitation. Staff of community alcoholism agencies in Manhattan and Long Island and in the Marcy and St. Lawrence service areas were most helpful in discussing how their services tied in with those of the State alcoholism treatment centers.

In accordance with Commission policy this report focuses on factual analysis and evaluation. Recommendations and program proposals are not presented since they are in the realm of policymaking and therefore the prerogative of the Legislature.

The audit was conducted by Richard Spaulding, Chairman; Patrice Eremin, and Evelyn McLauchlin. Word processing and graphics were provided by Dawn Hewitt. Bernard Geizer served as general editor while James Haag handled layout and production. Overall supervision was the responsibility of the Director.

The Commission is interested in hearing from the readers of its audits. Any comments or suggestions should be sent to the Director at the address listed inside the front cover of the audit.

The law mandates that the Chairmanship of the Legislative Commission on Expenditure Review alternate in successive years between the Chairman, Senate Finance Committee, and the Chairman, Assembly Ways and Means Committee. Senator John J. Marchi is the Chairman for 1983 and Assemblyman Arthur J. Kremer is Vice Chairman.

December 14, 1983

Sanford E. Russell
Director

I INTRODUCTION

Alcoholism

Alcoholism is a progressive disease. Why it occurs in some persons and not others is a matter of research and debate. However its effects are well known. It acts on the brain as a depressant and slows down brain activity. A person drinking large doses over long periods of time risks physical addiction and damage to the liver, heart, muscles, and digestive system.[1] It may result in disruption of families, loss of employment, drunk driving arrests, and financial difficulties. It generally advances through three stages. In the early stage tolerance to alcohol is increased and more alcohol is needed to become intoxicated. There may be drinking to relieve tension and guilt following drinking episodes. In the second stage there is daily drinking, hiding bottles of alcohol and a psychological dependence. The third stage results in shakes, hallucinosis, blackouts or memory losses, delirium tremens, and alcohol related medical problems such as cirrhosis, hepatitis, chronic gastritis, anemia, malnutrition, pancreatitis, and peripheral neuropathy.

The New York State Division of Alcoholism and Alcohol Abuse (DAAA) estimated that in 1960 there were 1,191,262 problem drinkers in New York State or 9.3 percent of the State's population age 18 and over or 6.6 percent of the State's total population of 18,082,187.[2] Problem drinkers are those who have serious alcohol problems requiring treatment. DAAA estimates that about half of the problem drinkers (595,600) have crossed the line and become addicted to alcohol.[3]

Purposes of Audit

DAAA operates 13 alcoholism treatment centers in State psychiatric centers spread across the State (Map 1). The purposes of this audit are to determine with respect to these 13 alcoholism treatment centers (ATCs):

--The role of the ATCs in treating alcoholics in relation to other treatment facilities and organizations,

--The effectiveness and efficiency of the ATCs,

--The adequacy of collections for services to patients.

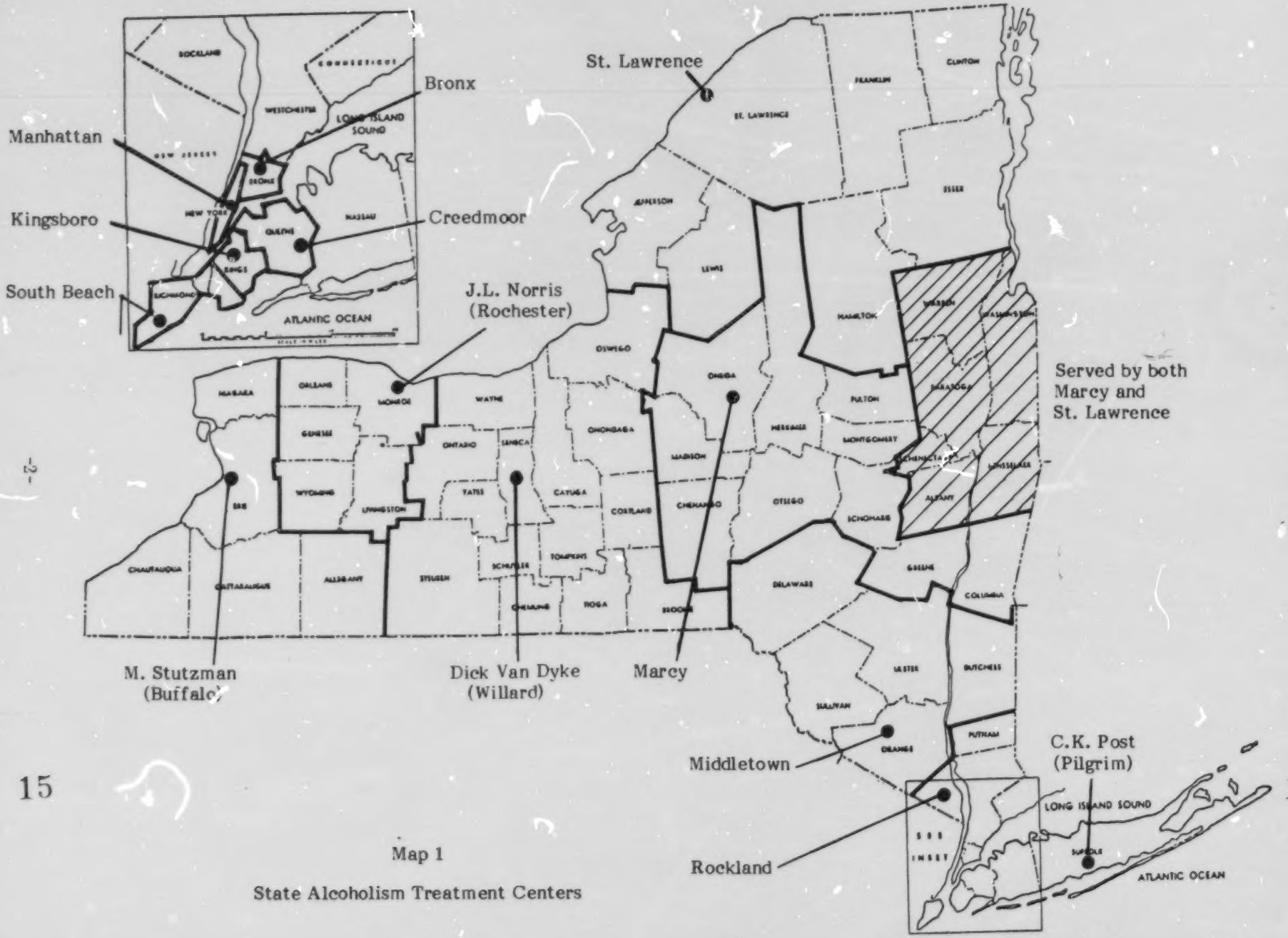
It is not the purpose of this audit to review the procedures of DAAA in providing grants to local governments which contract with community groups for services to alcoholics. This has been reviewed by the State Comptroller.[4]

Legislative Intent

The Mental Hygiene Law [5] makes the following points about alcoholism:

--Alcoholism as a disease can be treated. Positive results can be achieved.

--Polydrug abuse and the use of controlled substances in combination with alcohol are growing particularly among children and youth.



Map 1

State Alcoholism Treatment Centers

--These problems require prevention and early intervention efforts and other treatment capabilities across the State.

--The State of New York and its local governments have a responsibility for the prevention and early detection of alcoholism, alcohol abuse, substance abuse and substance dependence and for the comprehensively planned care, treatment and rehabilitation of alcoholics, alcohol abusers, substance dependent persons and substance abusers.

--It is the policy of the State to conduct coordinated research and to develop programs to further the prevention and early detection of alcoholism, alcohol abuse, substance abuse and substance dependence and to develop a comprehensive system of services to serve the full range of needs of alcoholics, alcohol abusers, substance abusers and substance dependent persons.

The Director of DAAA has the power to establish and operate alcoholism programs, treatment facilities and services for the prevention, treatment, and rehabilitation of alcoholics, alcohol abusers and significant others (relatives and friends) embodying all recognized or promising approaches, which shall be discrete from substance abuse treatment programs and services unless otherwise specified by the directors of alcoholism and alcohol abuse and of substance abuse services who shall seek the advice of the respective advisory councils.[6]

The Director of DAAA is further empowered to conduct evaluation studies using uniform methods as statistical bases, to determine the relative cost effectiveness of alcoholism programs and services throughout the State. This may be done either individually or in conjunction with other public or private agencies.[7]

The Mental Hygiene Law encourages local governments to develop in the community treatment services for those suffering from the diseases of alcoholism and substance abuse and to plan for the integration of community and State services and facilities for the mentally disabled.[8] By 1985, the Director of DAAA [in common with the heads of the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD) and the Division of Substance Abuse Services (DSAS)] must develop and recommend to the Governor and Legislature procedures giving counties and New York City the opportunity to:

--Review all proposed admissions of their residents to DAAA facilities.

--Propose discharges and review proposed discharges and placements of their residents from DAAA facilities to programs in the community.[9]

Organization of State Agencies

Department of Mental Hygiene

As of April 1, 1978, the New York State Department of Mental Hygiene was subdivided into four independent agencies: DAAA, DSAS, OMH, and OMRDD.[10] The creation of these agencies was to result in:

--Available resources being brought to bear more effectively in providing care and treatment for the different classes of disabled persons.

--Efficiencies in administration.

--Continued commitment of the State to maintain the highest quality of patient care both in facility and community based programs.

--Maximum opportunity for cooperation among the four agencies, particularly in reference to individuals with multiple disabilities.

Seven other agencies were created:

--The Office of Alcoholism and Substance Abuse. Within the Office was created a Commission on Alcohol and Substance Abuse Prevention and Education consisting of three members including a Chairman and the Directors of DAAA and DSAS. While the Office exists in the Mental Hygiene Law it is no longer funded and does not exist in fact.

--The Inter-Office Coordinating Council consisting of the Commissioners of OMH and OMRDD and Directors of DAAA and DSAS. The New York State Conference of Local Mental Hygiene Directors is to meet with the Council from time to time.[11] As of July 1983 the Council had two Committees, one on the multiply disabled and one on planning procedures. The Council must report annually to the Legislature on proper treatment models and suggested methods for treatment programs for multi-disabled alcohol and substance abusers.

--The Council for Mental Hygiene Planning consists of the heads of DAAA, DSAS, OMH and OMRDD and 15 members appointed by the Governor. Its primary purpose is to set measurable statewide goals and objectives to guide comprehensive planning, resource allocation and evaluation for State and local services for the mentally ill, mentally retarded, alcoholics and substance abusers.[12] Its goals with respect to alcoholism include: promote public awareness of alcoholism and alcohol abuse and support for alcoholism programming through the use of mass media; promote expansion of prevention and alcohol education efforts to reach specific target populations; expand identification and early intervention programming with emphasis on special populations; develop and maintain a comprehensive range of quality alcoholism treatment and rehabilitation services; work to assure the financial viability of the alcoholism service delivery system; promote research efforts to refine the data base for planning, program and policy development; and develop and maintain a cadre of professional staff in the health and human services delivery systems adequately trained in the field of alcoholism and alcohol abuse.[13]

--Four separate advisory councils to DAAA, DSAS, OMH, and OMRDD. The Advisory Council on Alcoholism and Alcohol Abuse consists of 24 members appointed by the Governor with the advice and consent of the Senate plus the Director of DAAA and the Chairman of the Conference of Local Mental Hygiene Directors. Its duties are to advise DAAA on the statewide five-year plan, review applications for construction of alcoholism treatment facilities, and review proposed rules and regulations of DAAA.[14]

Division of Alcoholism and Alcohol Abuse

Chart 1 shows the organization of DAAA. Its principal programs include the 13 alcoholism treatment centers; provision of financial assistance to counties and New York City which contract with community agencies providing alcoholism services; planning; certification of alcoholism facilities; alcohol and highway safety programs; and the Research Institute on Alcoholism.

Office of Mental Health

The 13 State alcoholism treatment centers are located in buildings operated as State psychiatric centers by OMH. There is a December 1981 memorandum of agreement between OMH and DAAA which outlines the support services provided by OMH to the DAAA alcoholism treatment centers. OMH is responsible for billings and collections for all DAAA patients. In order to determine the full cost of operating the alcoholism treatment centers OMH and DAAA are to undertake a joint review of the psychiatric center expenses in providing support services to the alcoholism treatment centers.

Department of Health

Effective in July 1983, the State Commissioner of Health became responsible for establishing standards for determining the necessity of care and service for alcoholism and alcohol abuse by hospitals. Regulations are to deal with appropriate level of admission, controlling length of stay, and provision of services.[15]

Methodology

The methodology for this audit included:

--Review of data from DAAA and OMH's management information systems. Special requests for data were also made.

--Interviews with personnel in central offices of DAAA, OMH, and the NYS Education Department, Office of Vocational Rehabilitation.

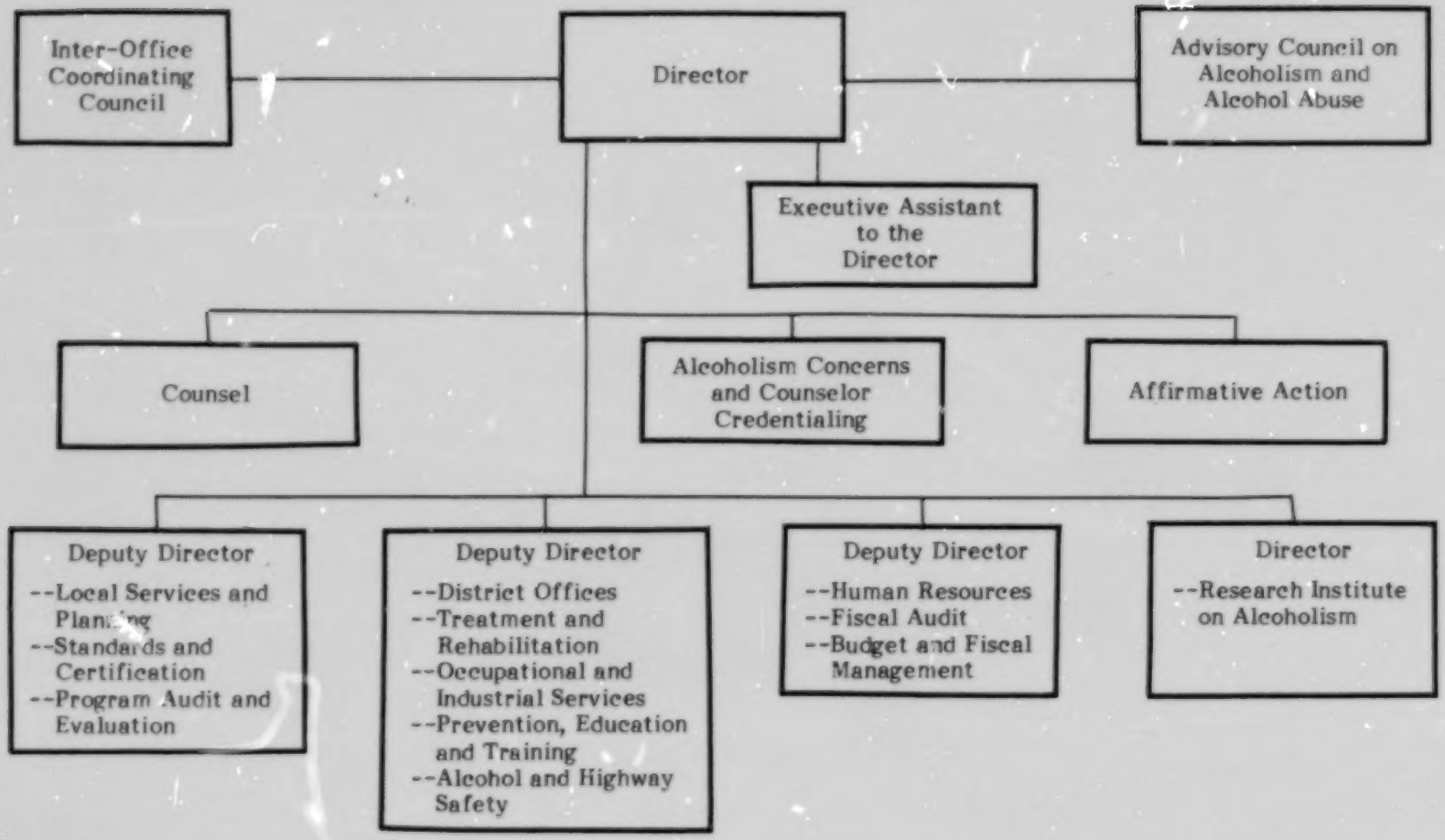
--On-site visits to all 13 State alcoholism treatment centers operated by DAAA.

--Interviews with providers of community services to alcoholics such as sobering-up stations, counseling services, rehabilitation, out-patient services, and halfway houses in areas served by C.K. Post Alcoholism Treatment Center at Pilgrim (Nassau and Suffolk Counties), Manhattan Alcoholism Treatment Center (Manhattan), and Marcy Alcoholism Treatment Center (Northeastern New York).

--Interviews with local public officials responsible for alcoholism services in New York City and in the counties of Nassau, Oneida, Saratoga, and Suffolk.

Chart 1

Organization Chart
N.Y.S. Division of Alcoholism and Alcohol Abuse



Source: LCER staff.

Chapter Summary

- DAAA estimates that there are over a million problem drinkers in New York State of whom half are alcoholics.

- The four agencies of the Department of Mental Hygiene including DAAA are to treat persons effectively and efficiently and to provide a high quality of care.

- Individuals who are both substance and alcohol abusers are to be served. The Inter-Office Coordinating Council is to report annually to the Legislature on how they are to be served.

- DAAA has the power to operate treatment facilities. Counties and the City of New York are also encouraged under the Mental Hygiene Law to develop community treatment services.

II STATE OPERATED TREATMENT PROGRAM

Description and Service Areas of Alcoholism Treatment Centers

The 13 DAAA operated alcoholism treatment centers (ATCs) are located in various regions of the State and have distinct service areas. According to DAAA, service areas are geographically bounded areas encompassing complementary systems of regional and local alcoholism service providers.[1] These specific service areas were set up to enable each ATC to integrate its services with those of other service providers meeting the needs of each community.

It is DAAA's policy to require all persons whose usual places of residence are within the specified service area of an ATC be served by that ATC. If a person from outside the ATC's service area seeks admission, the receiving ATC normally refers the client to the appropriate ATC and arranges for transportation. Exceptions to this policy can be made in the following instances:

--No vacant beds are available at the appropriate ATC, and an inordinate waiting period is projected,

--A previously treated patient is expected to benefit from treatment at a different ATC,

--Confidentiality of the patient is threatened by treatment at the normal ATC, or

--The patient requires certain treatment which can only be provided at an ATC equipped to furnish such treatment.

The 13 ATCs are located in the following regions of the State (See Map 1):

--The Middletown ATC is a 27 bed facility which serves the Mid-Hudson region of the State.

--The St. Lawrence ATC, located in Ogdensburg, is a 41 bed facility which provides sobering-up, detoxification and inpatient rehabilitation to clients residing in the Northern region of the State. In addition, clients from Albany, Rensselaer, Saratoga, Schenectady, Warren and Washington counties may be served by either the St. Lawrence ATC or the Marcy ATC.

--The Central region of the State is served by the Marcy ATC, a 60 bed inpatient rehabilitation facility located outside Utica in Oneida County.

--The Willard (Dick Van Dyke) ATC is a 30 bed facility in the Town of Willard which serves the Finger Lakes region of the State.

--Western New York is served by the Rochester ATC (John L. Norris) and the Buffalo ATC (Margaret A. Stutzman), a 30 bed facility. Rochester has 40 inpatient rehabilitation beds and a day rehabilitation program and has been designated by DAAA to serve the deaf and physically handicapped. Appropriate referrals are made to this ATC from other ATCs.

--The Rockland ATC in Orangeburg has 31 inpatient rehabilitation beds and 19 detoxification beds, as well as an outpatient clinic in Mt. Vernon. It serves Rockland, Westchester and Putnam counties.

--Nassau and Suffolk counties are served by the C.K. Post ATC located on the grounds of the Pilgrim Psychiatric Center in Suffolk County. Prior to June 1983, the C.K. Post ATC was located in Central Islip. The facility has 24 detoxification beds. 79 inpatient rehabilitation beds and 19 beds for the independent living unit.

--The Metropolitan New York City area is served by treatment centers which are located in each of the five boroughs: Manhattan ATC (60 beds), Creedmoor ATC in Queens (24 beds), Bronx ATC (24 beds), Kingsboro ATC (27 beds) and South Beach on Staten Island (25 beds). Each of these ATCs serves the borough in which it is located, although South Beach may also receive clients from Western Brooklyn, and Manhattan admits Hispanic clients from all areas of the State to its Latino program.

Patients and Capacity

The State alcoholism treatment centers in 1982-83 had beds in three types of services: detoxification, rehabilitation and community living:

	1982-83			
			% Occupied	
Service	Beds	Admissions	Actual	DAAA Goal
Detoxification	48	2,393	67	90
Rehabilitation	493	4,263	86	86
Community Living	19	58	47	90
Total	560	6,714	83	

See Appendix B, Agency response of DAAA, regarding changes in bed capacity made during 1983-84.

Admissions

In 1982-83 there were 6,714 admissions to the State operated alcoholism treatment center services comprised of inpatient rehabilitation, detoxification and community living (Central Islip). This is less than one percent of the estimated 1,191,262 problem drinkers in New York State and one percent of the estimated population addicted to alcohol. Table 1 shows admissions to the State alcoholism treatment center rehabilitation units for 1981-82 and 1982-83. Admissions increased from 1981-82 to 1982-83 for all of the ATCs except Central Islip which decreased by one percent and Creedmoor which decreased by 1.6 percent.

The largest percent increase in admissions was at Middletown; admissions increased from 168 to 223 or 32.7 percent over the one year period. The Director of Middletown told LCER staff that the facility has been able to utilize beds more effectively since

Table 1

Admissions for Rehabilitation
State Alcoholism Treatment Centers
1981-82 and 1982-83

Center	Admissions 1981-82	Admissions 1982-83	Change Amount	Change Percent
Bronx	127	156	+29	+22.8
Buffalo	359	389	+30	+8.4
Central Islip	418	414	-4	-1.0
Creedmoor	185	182	-3	-1.6
Kingsboro	130	149	+19	+14.6
Manhattan	517	602	+85	+16.4
Marcy	493	540	+47	+9.5
Middletown	168	223	+55	+32.7
Rochester	346	395	+49	+14.2
Rockland	369	391	+22	+6.0
St. Lawrence	271	298	+27	+10.0
South Beach	197	238	+41	+20.8
Willard	268	286	+18	+6.7
Total	3,848	4,263	+415	+10.8

Source: DAAA, Local Services Statistical Reporting System (LS-2C), July 13, 1983.

changing its policy of allocating a specific number of beds for each county in the Middletown service area. Middletown now maintains a waiting list of clients on a county basis but does not reserve beds that way.

Each alcoholism treatment center (ATC) has developed its own admission policy and screening forms. The screening form typically includes such information as the patient's name, address, telephone number, marital status, highest level of education, source of referral, history of alcohol use and its effects, degree of impairment in social or occupational functioning, drug use and present physical impairments due to alcohol use. The admission criteria did not vary significantly for the 13 ATCs. The basic criteria require that the client be:

--18 years or older except with parental consent or emancipated minor status,

--free of addictive drugs,

--dependent on alcohol but detoxified from alcohol anywhere from one day to a week, and

--free from any active psychosis or severe mental retardation.

Several of the ATCs told LCER staff that in order to qualify for admission to the ATC, the client has to present evidence of previous unsuccessful attempts at treatment on an outpatient basis. At Pilgrim ATC if a client has not had previous treatment he/she will probably be referred during the initial telephone screening to either an outpatient clinic or Alcoholics Anonymous (AA). Bronx requires that a client show that he/she has been unsuccessful at outpatient treatment or the client should have a history of more than two detoxifications in the last two years and failure to maintain sobriety. Creedmoor, Rockland, Middletown and Kingsboro have similar requirements.

In addition, about three percent of those admitted have been referred following an arrest for driving while intoxicated (D.W.I.). These include persons whose licenses have been suspended and have been referred for inpatient rehabilitation, persons whose licenses have been revoked and must be rehabilitated before a license is reissued, persons charged with driving while intoxicated whose cases have not been tried, and those who have been convicted and are on probation and must take rehabilitation as a condition of sentence.

LCER asked the 13 ATCs to indicate what their readmission policies for rehabilitation beds are for patients who left treatment against medical advice, those who previously completed treatment and those who failed to follow through with the aftercare plans for continued treatment and services after discharge. The majority of the ATCs' readmission policies were applicable for all types of discharges; however, the policies varied widely among the 13 ATCs. For example, Rochester, Kingsboro, Pilgrim and St. Lawrence stated that they have no specific policy on readmissions and each case is reviewed individually. There is no limit on the number of readmissions at these facilities, except St. Lawrence which only allows two admissions. The Buffalo ATC said that all clients are considered for readmission except in those cases where a patient was discharged early for infraction of the facility rules (e. g., drinking alcohol or using drugs). There is no limit on the number of readmissions at Buffalo.

Several ATCs, on the other hand, have time limits on readmission. Bronx and Creedmoor will consider readmission after six months from the time of discharge and neither facility has a policy on the number of readmissions. Manhattan requires a period of one year or longer since discharge and allows one readmission. Willard requires a period of six months if the treatment program was not completed, but will readmit after three months if the patient completed treatment and attended AA meetings. The remaining ATCs' readmission policies were variations of the above.

Occupancy Rates

LCER staff calculated occupancy rates for the 13 ATCs from DAAA figures of actual and possible patient days for 1981-82 and 1982-83. Table 2 shows that occupancy rates increased to 90 percent or more from 1981-82 to 1982-83 for all of the ATCs except Central Islip (53.5 percent), Rochester (81.7 percent) and St. Lawrence (81.7 percent). Although the occupancy rate at St. Lawrence did not reach 90 percent in 1982-83, it did increase by 11.2 percent which St. Lawrence attributes to a change in its service area in October 1982.

The occupancy rate at Central Islip ATC, 53.5 percent, was the lowest rate of any ATC in 1982-83.

Rockland ATC, was operating above capacity with a 114.5 percent occupancy rate in 1981-82 and a 115.6 percent rate in 1982-83. The implications of this rate in relation to DAAA operating certificate standards are discussed in Chapter III.

Table 2

Occupancy Rates for State Alcoholism Treatment Centers
Rehabilitation Beds
1981-82 and 1982-83

Center	Occupancy Rate 1981-82	1982-83	Change
Bronx	78.9%	95.4%	+16.5%
Buffalo	76.9	96.2	+19.3
Central Islip	65.4	53.5	-11.9
Creedmoor	80.3	91.8	+11.5
Kingsboro	85.7	93.1	+7.4
Manhattan	96.6	90.0	-6.6
Marcy	83.1	93.8	+10.7
Middletown	77.4	91.6	+14.2
Rochester	78.0	81.7	+3.7
Rockland	114.5	115.6	+1.1
St. Lawrence	70.5	81.7	+11.2
South Beach	78.9	90.6	+11.7
Willard	84.3	94.2	+9.9
Statewide Total	81.5	86.2	+4.7

Source: DAAA, Local Services Statistical Reporting System (LS-2C), July 13, 1983.

Rehabilitation

LCER staff visited each of the 13 State operated alcoholism treatment inpatient rehabilitation facilities to determine patient characteristics, treatment philosophies and methods, policies on multi-abusers, policies on handicapped, developmentally disabled and psychiatric alcoholics, discharge policies and aftercare plans and follow-up procedures. This section summarizes ATC responses to the LCER questionnaire used during field visits.

Patient Characteristics

The DAAA 1982 report, Systemwide Program Plans for State Operated Alcoholism Services (SOAS) states that "as the alcoholism provider network developed over the years, the clientele served by the SOAS system has consisted mostly of patients who are in advanced stages of alcoholism with chronic manifestations of the disease. In addition, they are overwhelmingly in the lower socio-economic population."[2]

Clients served by the State alcoholism treatment centers, especially those in the Metropolitan New York City area are those whose drinking problem is usually compounded by inadequate education, poor work history, family instability, social isolation and inadequate housing.

Sex

The majority of clients served by the State ATCs are men. On the average, 18.6 percent of the clients treated in State ATCs in 1981-82 were women. Manhattan ATC, which has a special Women in Treatment Program, stated in its 1982-83 Annual Program Management Plan that "many treatment agencies are geared toward a male population, this being a major reason why women do not come into treatment as readily as men do."[3]

Ten of the 13 ATCs indicated in their Program Management Plans that they have some type of women's group therapy, and all 13 ATCs designate a specific number of beds for women. However, the ATCs stated that they have difficulty keeping these beds filled with women and often, to alleviate a waiting problem, will use them for men rather than hold them open for women.

Age

Approximately one-third of the clients served in the State ATCs in 1982-83 were between 21 and 30 years old and about one-third were between 31 and 40. Manhattan ATC had a much older client population with about 65 percent in the 31 to 50 age range. Only 4.8 percent of the clients served by all of the ATCs were 20 years old or younger. The DAAA policy on admission and inpatient rehabilitation treatment of persons under age 18 states:

> Admission of any person under 18 will require his/her own written consent for treatment and the written consent of a responsible adult. A person under the age of 18 is permitted to give effective consent for medical, dental, health and hospital services under section 2504 of the New York State Public Health Law, if he/she has married or is the parent of a child. Such persons found suitable for informal admission to the rehabilitation service in accordance with section IA, may be admitted informally without additional consent.[4]

In the Spring of 1983, DAAA conducted a survey at the 13 ATCs to determine if the ATCs admitted clients under age 18 and what the youngest admission was under 18 years old. All of the ATCs excluding Willard, Marcy, Manhattan and South Beach admit clients younger than 18. The youngest was 16. The results of this survey correspond with the LCER staff finding that all of the ATCs which admit clients younger than 18 said they do so only in accordance with the above DAAA policy. Additionally, an adolescent client must exhibit a maturity which would enable him/her to benefit from an adult treatment program.

Several issues which were identified through the DAAA survey in regard to the treatment of adolescent clients were:

--The need for more structured adolescent programs and staff training focused on the unique needs of the adolescent,

--The need for the establishment of halfway houses for adolescent patients, and

--The need to treat the dual-addicted alcohol/drug patient.[5]

LCER staff asked each ATC to indicate how a client who is younger than 18 receives treatment if he or she is not admitted to the State treatment centers. Those ATCs which are located in the Metropolitan New York City area stated that adolescent clients are referred to outpatient counseling, private drug or alcohol rehabilitation programs, or halfway houses for adolescents. Those ATCs located in Upstate New York (Rochester, Buffalo, Middletown, and St. Lawrence) stated that there is a problem treating the teenage alcoholic or problem drinker because in most cases they are not mature enough to be treated in an adult facility and there is a lack of alcoholism rehabilitation programs specifically targeted for teenagers.

Ethnicity

Overall, the majority of clients admitted to the State ATCs in 1982-83 were White (64.2 percent); however, as Table 3 indicates, the ethnicity of clients varied depending on the location of the ATC. Bronx ATC admitted 52.5 percent Black and 28.5 percent Hispanic clients; Kingsboro admitted mostly Black clients (78.5 percent) and Manhattan admitted mainly Black (43.1 percent) and Hispanic (28.0 percent) clients. The Upstate ATCs served a predominately White client population.

Table 3

Ethnicity of Patients Admitted to
State Alcoholism Treatment Centers
1982-83

	Ethnicity - Percent				
Center	White	Black	Hispanic	American Native or Alaskan	Unknown
Bronx	19.0	52.5	28.5	0.0	0.0
Buffalo	65.6	29.3	1.3	3.8	0.0
Central Islip	84.1	12.6	1.5	0.0	1.8
Creedmoor	58.3	36.3	2.7	0.5	2.2
Kingsboro	9.4	78.5	4.0	0.0	8.1
Manhattan	26.1	43.1	28.0	0.4	2.4
Marcy	90.1	6.4	0.4	2.0	1.1
Middletown	79.9	12.9	6.7	0.0	0.5
Rochester	73.9	19.7	4.6	1.0	0.8
Rockland	62.0	34.4	3.4	0.0	0.2
St. Lawrence	86.2	9.6	0.0	4.2	0.0
South Beach	69.6	19.8	8.1	0.8	1.7
Willard	86.7	10.8	0.4	0.4	1.7

Source: Department of Mental Hygiene Information System, June 23, 1983.

DAAA Patient Characteristics Survey

DAAA conducted a statewide patient characteristics survey during a sample week in November 1981, to compare patient characteristics of clients admitted to the State operated alcoholism services, private for-profit services and publicly funded voluntary and county operated programs.[6] Although the data collected were only for a one week sample, the results show significant differences between the ATC clients and those served by locally sponsored programs. A comparison of employment status showed that 40.7 percent of those clients in the ATCs were not in the labor force (includes those who are unemployed and no longer seeking work in addition to housewives, etc.) compared to 16.6 percent for voluntary and county operated and 21.6 percent for private for-profit facilities.

The study also compared the potential or actual reimbursement sources for the treatment program. The majority of clients in the private for-profit programs pay for services through third party reimbursement (58.2 percent) or by self-payment (22.1 percent). For those clients who were in the State facilities, only 9.2 percent use third party payment and less than one percent use self-payment.

Multiply Disabled Clients

Several sections of the Mental Hygiene Law recognize the need for treatment of those clients who have more than one disability including mental illness, mental retardation, developmental disabilities, alcoholism, narcotic addiction and substance abuse. The preamble specifies the intent to serve the multiply disabled by stating:

> In order to assure that there will exist maximum opportunity for cooperation among these offices, particularly in reference to individuals with multiple disabilities . . . these offices are appropriately established according to the provisions of this act . . .[7]

Section 19.07 (a) establishes the powers and duties of the Division of Alcoholism and Alcohol Abuse, and in regard to the treatment of clients with multiple disabilities states:

> The division, through its director, shall have the power to . . . with the advice of the advisory council on alcoholism and with the assistance of any interdepartmental council . . . promote, establish, coordinate and conduct unified programs for prevention, diagnosis, treatment, aftercare, rehabilitation . . . in the field of alcoholism, in cooperation with such other federal, state, local and private agencies . . .[8]

Finally, section 5.05 (b) of the Mental Hygiene Law, in establishing an Inter-Office Coordinating Council, makes a provision for the treatment of the multiply disabled client by stating:

> . . . an inter-office coordinating council, which, consistent with the autonomy of each office . . ., shall ensure that the state policy for the prevention, care, treatment and rehabilitation of mental illness, mental retardation and developmental disability, alcoholism, and substance abuse is planned, developed and implemented comprehensively; that gaps in services to the multiply disabled are eliminated and that no person is denied treatment and services because he suffers from more than one disability . . .[9]

LCER staff examined the extent to which the State operated alcoholism treatment centers serve the multiply disabled client; specifically those clients who have the disease of alcoholism as well as a drug addiction, mental illness, developmental disability, mental retardation or physical handicap.

Alcoholism and Drug Abuse

The use of alcohol in combination with other drugs ranging from Valium and marijuana to heroin has become more and more prevalent. The 1982 Califano Report on Drug Abuse and Alcoholism to the Governor of New York State stated that "there are proportionately fewer 'pure' alcoholics. Virtually all of the alcoholics in treatment . . . in the course of this study . . . were not only drinking but taking other drugs as well--usually Valium and barbiturates, often pot, less frequently hard drugs like heroin or cocaine."[10]

The U.S. National Institute on Drug Abuse, collected data from the Drug Abuse Warning Network (DAWN) on drugs mentioned most frequently in emergency room episodes in 1981. The data are based on 819 emergency rooms nationally, 19 of which were in the Buffalo area and 54 were in the New York City area. The DAWN system reported that:

--During emergency room episodes, alcohol-in-combination with another drug accounted for 23.7 percent of the total episodes mentioned in 1981 for the U.S. in total; it accounted for 26.2 percent of the episodes in New York City and for 28.5 percent in the Buffalo area. It was ranked first as the drug mentioned most frequently--other drugs mentioned were Valium, heroin, aspirin, methaqualone, cocaine and marijuana.

--The eight drugs taken most frequently in combination with alcohol mentioned in emergency room episodes for the U.S. in total, in order of the most frequently mentioned were Valium, marijuana, methaqualone (Quaalude), heroin/morphine, cocaine, aspirin, flurazepan (Dalmane) and amphetamines.[11]

In 1978, the Inter-Office Coordinating Council (IOCC) Task Force on Multi-Disabilities conducted a survey to determine the number of multi-disabled persons receiving service in State operated inpatient and outpatient, local government and voluntary agency programs.[12] The results of this survey also support the prevalence of multi-abuse of drugs and alcohol. It showed that a substantially higher percentage of individuals with a primary diagnosis of alcoholism or substance abuse are multi-disabled than those individuals with a primary diagnosis of mental illness or developmental disability. The survey also found that for those clients who had alcoholism as a primary disability, 16.1 percent had substance abuse as a secondary disability. For those clients for whom substance abuse was the primary disability, 15.8 percent had alcoholism as a secondary disability.

All of the above data support the fact that there is a population of poly-abusers or multi-disabled clients who may or may not receive proper treatment for one or more drug problems. To determine the State operated ATC policies on the treatment of multi-abusers, LCER staff asked each of the 13 ATCs how they treat persons who show evidence of drug dependence or who are on methadone maintenance upon screening for admission to the ATC.

The responses from individual ATCs varied depending upon what type of drug the client was using at the time of admission. Eight of the ATCs stated that they do not admit anyone actively using drugs of any kind but will admit patients who have a history of drug abuse. The Central Islip facility stated that it does not admit anyone using heroin but will admit a client who is using marijuana, cocaine, amphetamines or LSD. It will admit those on methadone to detoxification but not to rehabilitation. Rockland, Marcy, and Buffalo also said they do not admit anyone using "hard drugs" (heroin or other opiates) but they can treat those clients using Valium or other minor tranquilizers, amphetamines or marijuana.

None of the ATCs admit clients who are on methadone maintenance to rehabilitation except Rochester. Methadone maintenance is the main method of treatment funded by the Division of Substance Abuse Services to combat heroin addiction. At Rochester[13] the policy regarding the treatment of alcoholics with a drug problem is:

> Patients presenting drug abuse problems are admitted to the facility if they, in addition to the drug abuse problem, have alcohol abuse . . . Drug abuse services are an integrated part of the . . . program . . .

With regard to methadone maintenance, the Director of the Rochester ATC said:

> We are not a licensed facility to provide methadone maintenance although we have treated a methadone maintenance patient. Coordination with the methadone maintenance program was effected and the patient left our agency each morning to receive methadone and was returned to the agency. . .

The problem of treating the methadone maintenance client in State alcoholism treatment centers is primarily a Metropolitan New York City issue, although methadone maintenance clients may occasionally show up at Buffalo and Rochester. The ATCs in the New York City area all said they refer methadone maintenance or hard drug users either to drug detoxification programs, methadone clinics, or drug rehabilitation programs depending on what type of treatment the individual appears to need. The principal reason offered for non-admission is that ATC administrators regard methadone and alcohol as "mind altering" drugs. They believe consistency requires that patients be told to cease taking all mind altering drugs.

This type of referral process and non-admission of clients on methadone or hard drugs by the ATCs is noted in the 1980 IOCC Committee on the Multiply-Disabled follow-up study on the treatment of multiply-disabled persons in New York State. This study found:

--Of the multiply-disabled applicants who were admitted to both community and State alcohol treatment, 41 percent suffered from drug abuse problems. Fifty eight percent of the multiply-disabled applicants to substance abuse services were reported to have alcohol abuse problems.

--The alcohol detoxification programs that were included in the study reported rarely admitting persons physically dependent upon alcohol and opiates or sedatives because of their inability to provide the medical services required during dual substance detoxification.

--Most alcohol abuse rehabilitation, day treatment, outpatient and halfway house programs report requiring three to six months of drug abstinence as a general criterion for admission.

--Substance abuse programs reported generally not admitting persons physically dependent upon alcohol, and some agencies reported requiring three to six months of documented sobriety. In all cases, substance abuse agencies reported difficulty obtaining alcohol treatment services through referral processes because of the drug abstinence requirements of alcohol services.[14]

Alcoholics Who Are Physically Handicapped, Developmentally Disabled and Psychiatric

LCER staff asked each of the 13 ATCs what their admission and referral policies are regarding those clients who have a physical handicap, mental retardation/developmental disability, or psychiatric problem. All of the State ATCs will admit persons with physical handicaps other than paraplegics as long as the clients are able to benefit from the treatment and the physical layout of the facility does not preclude a handicapped client's mobility (e. g., the Buffalo, St. Lawrence and Willard ATCs all have several floors which are only accessible by stairs). Also, the ATCs will not admit anyone with serious medical problems requiring general hospital treatment. The Rochester ATC has been designated by DAAA to serve the physically handicapped from the service areas of Buffalo and Willard ATCs and the deaf from throughout the State.

The incidence of clients with mental retardation/developmental disabilities in alcoholism treatment programs is low as evidenced by the Inter-Office Coordinating Council's 1978 survey of multiply-disabled clients which found that for those clients who had a primary disability of alcoholism, only 2.3 percent had a secondary disability of mental retardation. The State ATCs also indicated to LCER staff that clients with developmental disabilities are not usually referred to alcoholism treatment. In cases where such a client is referred, they can be treated for their alcoholism depending on the severity of their mental retardation; if they are able to understand the program and benefit from treatment, they are admitted to the ATC.

The most prevalent disability in combination with an alcoholism problem is mental illness. In the IOCC's 1980 follow-up study on the multiply-disabled, 57 percent of the applicants to alcohol treatment were reported to suffer from mental illness problems. The IOCC report also found:

--Alcohol detoxification programs reported rarely admitting the mentally ill with cognitive or affective disorders or with violent or suicidal behavior because alcoholism agencies lack the staffing ratios and the expertise needed to manage this population.

--Most alcohol abuse rehabilitation, day treatment, outpatient and halfway house programs report requiring three to six months of intact cognitive and verbal abilities and socially acceptable behavior as general criteria for admission. Persons with long histories of significant mental illness frequently fail to meet these admission criteria.

--Thirty-six percent of the multi-disabled applicants to mental health services were considered to have alcohol abuse problems reported typically requiring three to six months of documented abstinence from alcohol as an admission criterion.[15]

LCER staff found that the ATCs' policies regarding the admission of psychiatric clients corresponded with the IOCC study. Most of the State ATCs will admit psychiatric clients only if they can be controlled within the program without drugs or additional staff. However, Pilgrim and Kingsboro will admit psychiatric patients who are on psychotropic drugs if their psychosis is manageable. Kingsboro ATC makes a special effort to treat the psychiatric alcoholic. In response to the LCER questionnaire Kingsboro stated that they do admit some psychiatric patients on direct admission, or psychiatric patients from the Kingsboro Psychiatric Center are permitted to use the alcoholism treatment center on a day basis. DAAA personnel at all ATCs will provide consultation and recommendations to OMH personnel who are treating psychiatric patients on psychiatric wards who also are alcohol abusers.

Methods of Treatment and Rationale

Treatment Philosophy

The State alcoholism treatment centers varied in their philosophy of the causes and effects of alcoholism. All 13 ATCs view alcoholism as a disease. About half of the ATCs stated that there are causes of the disease stemming from physiological, psychological and behavioral factors. However, most qualified their responses by stating that the exact causes of the disease are still debated and more research is needed in this area. Central Islip (Pilgrim), Creedmoor, Rockland and Middletown ATCs felt that heredity played a part in causing the disease of alcoholism in certain individuals. The remaining ATCs stated that the causes of the disease are unknown, but the disease produces physiological, psychological, social and behavioral effects in the alcoholic.

Treatment Methods

All of the State ATCs use similar treatment methods in rehabilitating the alcoholic. The specific treatment interventions are provided by multi-disciplinary teams. The most common methods used are treatment for:

--Physiological effects of the disease including physical exams, nutritional diet, vitamins, alcohol education, and exercise;

--Psychological effects including individual and group counseling, psychological testing, group therapy, relaxation therapy, assertiveness training and Alcoholics Anonymous; and

--Social or behavior effects including family therapy, housing assistance, job training referral, recreation, occupational therapy, and audio-visual education on alcoholism.

The treatments most stressed and considered the most helpful by the majority of ATCs are group therapy and Alcoholics Anonymous. The Buffalo ATC considers one-to-one therapy most important and the Middletown and Kingsboro ATCs felt that educating the client about the disease of alcoholism was stressed the most in their treatment programs. LCER staff asked each ATC director, "Is the goal of treatment total abstinence or partial abstinence or does it vary by patient?" The goal of treatment at all 13 ATCs was said to be total abstinence from alcohol. However, the Division of Alcoholism and Alcohol Abuse qualified the treatment goal of the ATCs by stating in a

letter to LCER staff on October 27, 1983: "The goal of treatment at all 13 ATCs is to improve patient functioning, equipping them with the understanding, acceptance and tools needed to achieve abstinence with minimum relapse."

Disulfiram Therapy

Disulfiram is a drug administered to alcoholics which causes an extremely unpleasant reaction when alcohol is ingested and is used as a deterrent to drinking. The disulfiram-alcohol reaction produces flushing, throbbing in the head and neck, respiratory difficulty, nausea, chest pain, hyperventilation, blurred vision and confusion.[16] In severe reactions there may be respiratory depression, cardiovascular collapse, heart failure, unconsciousness, convulsions and even death. The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases. Usually, disulfiram will not cause a reaction 72 hours after a patient has discontinued to use it; however, in some cases one or even two weeks after a patient has taken his last dose of disulfiram, ingestion of alcohol may produce unpleasant symptoms. The patient information sheet published by one manufacturer states "it should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis, or insufficiency . . . is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses and hypersensitivity to disulfiram."[17]

DAAA has no overall policy governing the prescription and use of disulfiram in the State operated ATCs and has left the decision of whether to prescribe the drug up to the individual ATCs. LCER staff asked each facility director whether disulfiram was used in the treatment of alcoholics. The use of disulfiram by the State ATCs varied widely:

--Disulfiram is used in all of the State ATCs except St. Lawrence and Middletown in which it was described as "potentially dangerous."

--At Creedmoor ATC the use of disulfiram is a mandatory criterion for admission. All patients must use this drug unless it is medically contraindicated.

--Ninety percent of the patients at Kingsboro use disulfiram and the use of this drug is encouraged during treatment.

--Ten to 20 percent of the patients at Buffalo, Bronx, Central Islip, and Rochester use disulfiram.

--At Manhattan, South Beach, Marcy, Rockland, and Willard, disulfiram is administered on a voluntary basis if requested by the patient.

The dangerous side effects of the use of disulfiram at Manhattan ATC have been documented. An article by McConchie, Panitz, Sauber and Shapiro for the Journal of Studies on Alcohol states that:

> . . . five among 2,082 consecutive admissions to this hospital [Manhattan ATC] experienced de novo seizures while undergoing mandatory disulfiram therapy. The median number of days on disulfiram was 26 (range 10 to 31). Our patient's history and the nature of the convulsive episodes might suggest a diagnosis of withdrawal seizures, convulsions occurring after 32 days of abstinence and in the absence of accompany-

ing symptoms suggestive of alcohol withdrawal argue against ascribing them to ethanol withdrawal alone.[18]

LCER staff requested a list of all de novo seizures by ATC patients while undergoing disulfiram therapy from January 1, 1977 to July 1983 exclusive of those with diagnoses of idiopathic and posttraumatic epilepsy or histories of alcohol withdrawal seizures. In response, the Research Director at Manhattan ATC developed a framework for a study to be undertaken at each ATC using disulfiram. By using the journals kept by ward charges and nursing staff, as well as the medical admissions and medical discharge summaries, all persons who present a history of one or more seizures or sustained one or more seizures during their stay in the ATC would be identified. However, a letter to DAAA from the Research Director at Manhattan ATC states "as this is a retrospective study, there will be much missing or incomplete data; also I have found that when patients on (disulfiram) experience adverse reactions, not infrequently someone has attempted to remove all mention of the drug from the chart in question."[19]

The study proposes to classify the target population according to the presumed nature of the seizure such as epileptic, posttraumatic epileptic, alcohol intoxification epileptic, alcohol withdrawal epileptic, de novo, and miscellaneous. The target population would then be further subdivided according to medication groups such as Dilantin (for epilepsy) disulfiram, Dilantin plus disulfiram, or no medication. Proportions of each group sustaining seizures while at the ATC would then be compared.[20] DAAA told LCER staff that they plan to undertake this study.

Discharge Policies and Aftercare

In addition to the normal discharge from a State ATC after the required course of treatment has been completed, a client at the ATC may be discharged in the following manner:

--Against medical advice (AMA). The patient requests and is discharged from the ATC against the advice of the medical and clinical treatment staff. Since patients are admitted on an informal basis they are legally free to leave at any time.

--Discharge from leave status, in which a patient fails to return while on a weekend or day leave pass from the ATC.

--Administrative discharge. A patient is immediately discharged before the completion of treatment for violating ATC rules. Infractions include fighting, use of alcohol or drugs, violating confidentiality of other patients or unwillingness to participate in treatment.

--Early discharge for medical or psychiatric reasons.

Each ATC determines its own discharge policies; however, the reasons for early discharge listed above are indicative of the policies of all 13 ATCs. Regardless of the method of discharge, all of the ATCs stated that they make referrals for aftercare of all released clients. A caveat to this policy is that the client must give his or her consent in order to be referred to aftercare services upon termination of stay at the ATC. Often clients are "lost" after leaving the State ATC because they have not consented to referral to an aftercare agency.

A criterion for discharge from all the State ATCs is that the client shall have a specific aftercare plan for continued alcoholism services as well as other supportive services based on individual needs. The typical services a client may be referred to would include Alcoholics Anonymous, alcoholism outpatient clinics, halfway houses or other living arrangements, social welfare agencies and employment services.

Office of Vocational Rehabilitation

The New York State Education Department, Office of Vocational Rehabilitation (OVR), is the State agency responsible for the provision of vocational rehabilitation services to physically and mentally handicapped persons. Services provided by OVR included evaluation of rehabilitation potential, counseling and guidance, physical and mental restoration services, and placement in suitable employment.

The majority of the 13 State alcoholism treatment centers expressed dissatisfaction with OVR services to their clients. As of July 7, 1983 only two ATCs, Willard and Rochester, had cooperative service agreements with OVR. The source of this dissatisfaction with OVR stems from the understanding by the ATCs that there is a six month sobriety period required before OVR can provide services to recovering alcoholics. The Division of Alcoholism and Alcohol Abuse has a cooperative agreement with OVR which states:

> . . . DAAA will encourage all funded and/or certified community-based treatment programs to refer to OVR individuals perceived as potentially eligible for OVR's services . . . DAAA will encourage these community-based treatment facilities to designate an appropriate staff person to act as liaison with the OVR area offices in order to facilitate continuity of services.[21]

The only eligibility criteria mentioned in this agreement between DAAA and OVR are: 1) the presence of a physical or mental disability which, for the individual, constitutes or results in a substantial handicap to employment; and 2) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.[22] The agreement makes no mention of a sobriety requirement.

LCER staff asked the Regional Director of Operations at OVR if OVR requires a six month abstinence period for recovering alcoholics and, if so, how this requirement affects clients in State ATCs. OVR replied that there is a sobriety requirement included in OVR regulations which states:

> A history of alcoholism or drug use does not automatically make a person eligible for services. Eligibility should generally be based on the diagnosis of substance abuse with resultant limitations that are a substantial handicap to employment and evidence of abstinence for six months. The evidence of abstinence should not be based on the client's statement alone.[23]

The OVR regulations also state that the acceptance of referrals not meeting the six month sobriety period may be considered at the discretion of the Area Office Manager. The OVR Regional Director also added that exceptions are made in cases in which an individual exhibits a need and willingness to stay in the OVR program. She said that OVR was losing a high proportion of its alcoholic clients without the six month sobriety requirement due to a lack of commitment and a return to drinking. The Regional

Director told LCER staff that she was not aware that there was a problem in ATC clients gaining access to services. OVR would like to reverse this situation and provide services to ATC clients.

Detoxification

In addition to inpatient rehabilitation, Central Islip, Rockland and St. Lawrence provide detoxification services. Detoxification is a process intended to rid the body of alcohol and promote recovery from its effects. The process of detoxification is usually medically supervised by a physican or other qualified medical personnel and includes a physical examination, medical history, administration of drugs to ease withdrawal symptoms (Librium) and maintenance of a proper nutritional diet. A client usually stays in detoxification between five and seven days.

Total admissions to rehabilitation and the number and percent of those admissions which came directly from detoxification for 1982-83 were as follows:

	Rehabilitation Admissions	Rehabilitation Admissions from Detoxification	
		Number	Percent
Central Islip	414	144	34.8
St. Lawrence	298	131	44.0
Rockland	391	386	98.7
Total	1,103	661	59.9

Although almost all of the admissions to rehabilitation were from detoxification at Rockland, not all of those patients who go through detoxification continue with rehabilitation as shown below:

	Total Detoxification Admissions	Detoxification Admissions into Rehabilitation	
		Number	Percent
Central Islip	1,632	144	8.8
St. Lawrence	144	131	91.0
Rockland	617	386	62.6
Total	2,393	661	27.6

On the other hand, at St. Lawrence there seems to be a direct flow of clients from detoxification to rehabilitation with 91 percent of those entering detoxification going on to inpatient rehabilitation.

There is no limit to the number of times a client may be readmitted to detoxification at the three ATCs; however, the readmission rates varied considerably. The readmission rate to detoxification at Central Islip in 1982-83 was 44.7 percent or almost half of the clients. At St. Lawrence, the readmission rate was only 2.1 percent.

Central Islip ATC did identify overutilization by patients of detoxification beds as a problem in 1982. The Utilization Review Committee found that during March 1982 the detoxification unit was being used by patients who did not have an alcohol problem requiring a medical detoxification or who were impaired; impairment was documented by the use of a breathalyzer. A study of prior admissions of this same population indicated that stays were as short as 14 hours and in most instances the patients were readmitted on the same day of discharge.[24]

This problem was presented to the DAAA Long Island Alcoholism Regional Coordinator. Corrective action consisted of patients screening at the point of entry to determine appropriateness of admission, and referrals were made depending on the presenting problem. Out-of-catchment area patients were referred back to their county of residence and patients requiring shelter were referred to Suffolk County Social Services.

One goal of the DAAA 1982 Systemwide Program Plans for State Operated Alcoholism Services is to transfer the service components other than inpatient rehabilitation, including detoxification, to local sponsorship. DAAA provided LCER staff with a report on the status of transfer of the detoxification units as of May 5, 1983. In reference to the Rockland detoxification unit, DAAA reported that the Summit Park Hospital of the Rockland County Department of Mental Health has submitted an Article 28 application to the New York State Department of Health (DOH) to establish a detoxification program which would replace the Rockland unit. DAAA stated that the date of transfer would not be possible before January 1, 1984. (See Appendix B, agency response of DAAA, regarding subsequent developments on Summit Park.)

The progress of the Article 28 application submitted by Summit Park Hospital was reported to LCER staff by DOH. DOH is waiting for finalization of architectural standards by DAAA so that the Article 28 review can be completed. DOH also stated that it anticipates a fall 1983 review by the State Hospital Review and Planning Council if DAAA formalizes its architectural standards by September 1983.

The Canton-Potsdam Hospital has been identified as a local provider to replace the detoxification unit at St. Lawrence. DAAA reported that discussions with DOH have been initiated so that a scatter-bed detoxification phase (detoxification beds are spread throughout the hospital rather than being contained in a discrete unit) can occur prior to full Article 28 approval for a discrete alcoholism detoxification unit. DAAA also stated that the scatter-bed service may be operational by July 1, 1983. However, as of the June 28, 1983 visit by LCER staff to St. Lawrence, the detoxification unit was still fully operational at the ATC and no transfer had occurred.

As of May 1983, DAAA stated that two potential sponsors in Suffolk County had been identified to provide detoxification services to replace the Pilgrim ATC unit--Southside Hospital in Bay Shore and St. John's Episcopal Hospital in Smithtown. DAAA stated that an issue in the transfer was the matter of providing funding for alcoholism specific counseling staff at the hospitals and the submission and approval of the Article 28 applications by DOH. DAAA also told LCER staff that Southside Hospital may provide detoxification beds on a scatter-bed basis which does not require Article 28 approval by DOH.

DOH responded to LCER staff's inquiry of the status of the hospitals' Article 28 applications by stating that Southside Hospital had not submitted an Article 28 application and St. John's Episcopal Hospital had submitted an application for construction of an additional floor which would include 15 detoxification beds. However, processing of this

application has been delayed in accordance with the DOH moratorium on Article 28 approvals.

Independent Living Unit

Pilgrim ATC (formerly Central Islip) has an independent living unit which consists of 19 beds and is similar to a community residence. Patients who successfully complete the rehabilitation program and are unable to return to the community because of lack of housing and employment, marital problems requiring emotional or psychological independence, or severe social adjustment are assessed for a continuous stay in the independent living unit. To enter the program, the client must be employed and is projected for a length of stay of either six or 16 weeks, depending on the degree of stability. Patients in the independent living program must establish a savings account from their earnings, participate in early morning activities of daily living, and attend group therapy and AA meetings.

Forty-nine clients were admitted to the independent living unit in 1981-82 and 58 were admitted in 1982-83. The occupancy rate was approximately 56 percent in 1981-82 and 47 percent in 1982-83. Although this unit is underutilized, DAAA has not made an attempt to transfer this program to local sponsorship. DAAA told LCER staff that the local community in Suffolk County has not been receptive to the establishment of halfway houses for alcoholics. The 1982 DAAA Systemwide Program Plans state:

> The community residence component at the Charles K. Post [Pilgrim] ATC is a very needed service since there are now no alcoholism community residences in Suffolk County . . . it is not only a very needed service, but is very cost effective. The Division will work actively with the local governmental unit in an attempt to transition this service during fiscal year 1984-85.[25]

DAAA Systemwide Program Plans for State Operated Alcoholism Services

In December 1982 DAAA completed a management study which was conducted in response to legislative requirements which stated:

> The director of DAAA is directed to submit to the Fiscal Committees no later than December 31, 1982, a management study of the State-operated system, with proposals for clinically-indicated staff-to-patient ratios, improved bed utilization projections, and, if possible, methods for establishing varying levels of care based on need. Such a study should also address continuing needs for State-operated services, with proposed community-based service models which would provide comparable levels of care.[26]

This section reviews the results of this study regarding DAAA's policy of standardizing length of stay, establishing occupancy expectations for each ATC, projecting admissions and patient days, and transferring other than inpatient rehabilitation services to local sponsorship.

Length of Stay

According to the DAAA Systemwide Program Plans, the variations in the length of stay are due to several factors which include the profile of the population at each ATC, the extent to which other service components are available in the local treatment networks, the categories of services provided within each ATC, and the program approaches which the ATCs have independently developed.

As a result of this study DAAA has determined that for the ATC inpatient rehabilitation services the expectation for lengths of stay is a range of 28 to 42 days, with an average of 35. The report further qualifies this expectation, however, by stating:

> . . . a small number of ATCs traditionally have a larger proportion of patients whose physical and psychosocial defects and/or degree of disaffiliation continue to necessitate a longer length of stay for completion of the treatment regimen.[27]

Table 4 shows the actual lengths of stay for 1981-82 and 1982-83, the projected length of stay for 1982-83, and the actual and projected reductions or increases in length of stay. As can be seen from the table, there is variation in the length of stay for both years.

Table 4

Actual Length of Stay 1981-82 and Projected and Actual Length of Stay 1982-83 for State Operated Alcoholism Treatment Centers Rehabilitation

Center	Actual 1981-82	Projected 1982-83	Actual 1982-83	Projected Increase or Decrease	Actual Increase or Decrease
Bronx	54	52	55	-2	+1
Buffalo	24	26	27	+2	+3
Central Islip	42	42	37	0	-5
Creedmoor	40	39	44	-1	+4
Kingsboro	67	51	62	-16	-5
Manhattan	41	45	33	+4	-8
Marcy	38	35	38	-3	0
Middletown	44	37	42	-7	-2
Rochester	32	28	31	-4	-1
Rockland	34	35	33	+1	-1
St. Lawrence	34	36	37	+2	+3
South Beach	36	35	36	-1	0
Willard	35	35	36	0	+1
Statewide Total	38	38	37	0	-1

Source: DAAA, Systemwide Program Plans for State Operated Alcoholism Services, December 1982, and Local Services Statistical Reporting System (LS-2C), July 13, 1983.

Kingsboro had the highest length of stay at 67 and 62 days respectively and Buffalo had the lowest length of stay at 24 and 27 days respectively. DAAA expected length of stay to decrease at all ATCs except Buffalo, Manhattan, Rockland, and St. Lawrence in accordance with its plans to standardize length of stay. However, in several cases reductions were projected which were not reached (Bronx, Creedmoor, Kingsboro, Marcy, Middletown and South Beach) and at several ATCs the length of stay increased (Buffalo, Creedmoor, St. Lawrence and Willard) from 1981-82 to 1982-83.

LCER staff asked each ATC if after admission, clients are placed in specialized programs based on a pre-determined length of stay, to determine if this policy would affect the variation in length of stay among facilities. Eight of the centers do place clients in program tracks of various lengths based on the clients' condition and treatment needs. For example, Manhattan has a three week program (SOAR) for individuals who have support systems such as families, jobs and housing and who are not in need of long term rehabilitation; and a six week program (CORE) for patients who do not have support systems and whose alcoholism is at a more advanced stage. CORE patients typically have greater medical problems than SOAR patients.

Marcy has program tracks consisting of four, six and eight weeks. Clients are placed in a program according to their stage of alcohol dependence and based on physical signs, social and occupational functioning, prior treatment and family support.

Rochester, Creedmoor, Kingsboro and Buffalo do not place clients in program tracks, but have a maximum length of stay. Buffalo, which has the shortest average length of stay, requires that a client stay no more than 30 days.

Whether or not an ATC has program tracks based on length of stay does not seem to affect its average length of stay as greatly as the type of client it serves. In the case of Kingsboro, which had an average length of stay of 62 days in 1982-83, the typical patient is characterized by low social stability and moderate to severe socio-economic deprivations such as unemployment and lack of housing. Kingsboro patients also have numerous physical and nutritional problems. The wide range of individual problems at Kingsboro has led to broad range of length of stay aimed at the needs of the individual. The highly debilitated client populations at Kingsboro and Bronx have been identified in the DAAA Program Plans as a treatment issue which would allow for a longer length of stay at these facilities.

Occupancy Rates

According to the DAAA Systemwide Program Plans, the expected occupancy rate for all ATCs, beginning in 1983-84 is 90 percent. Prior to 1983, 85 percent was the minimum expected occupancy. The report states that the major factors which would affect this goal are the expected substantial increase in the rate of turnover due to the shorter length of stay projected and the bed capacity.

Table 5 show the actual occupancy rates for 1981-82 and 1982-83, the projected rates for 1982-83, and the increase or decrease from 1981-82 to 1982-83. DAAA met its 1982-83 goal for an 86 percent occupancy rate for all of the ATCs. All of the ATCs met or exceeded the DAAA projected occupancy rates for 1982-83 except Central Islip and Manhattan. The greatest increase in occupancy occurred at Buffalo, which increased from 77 percent in 1981-82 to 96 percent in 1982-83. Central Islip experienced the greatest drop in occupancy, from 65 percent to 54 percent.

Table 5

Actual and Projected Occupancy Rates
for Inpatient Rehabilitation
1981-82 and 1982-83

Center	Actual 1981-82 Rates	Projected 1982-83 Rates	Actual 1982-83 Rates	Actual Increase or Decrease 1981-82 to 1982-83
Bronx	79	90	95	+16
Buffalo	77	90	96	+19
Central Islip	65	78	54	-11
Creedmoor	80	90	92	+12
Kingsboro	86	90	93	+7
Manhattan	97	98	90	-7
Marcy	83	85	94	+11
Middletown	77	88	92	+15
Rochester	78	82	82	+4
Rockland	115	90	116	+1
St. Lawrence	71	80	82	+11
South Beach	79	87	91	+12
Willard	84	85	94	+10
Total	82	86	86	+4

Source: DAAA, Systemwide Program Plans for State Operated Alcoholism Services, December 1982, and Local Services Statistical Reporting System (LS-2C), July 13, 1983.

Admissions

DAAA projected annual admissions in its Systemwide Program Plans as a systemwide goal based on the goals for length of stay, bed capacity, occupancy, and staffing. Table 6 shows the 4,507 projected and 4,263 actual rehabilitation admissions for 1982-83. Actual admissions were five percent less than projected. Central Islip showed the greatest difference in admissions; actual admissions in 1982-83 were 229 less than projected. Bronx, Creedmoor, Kingsboro, Middletown, Rochester and St. Lawrence all had fewer admissions than projected although the differences were not significant.

Transfer of Services Other Than Inpatient Rehabilitation

The DAAA Systemwide Program Plans calls for the transfer of functions other than inpatient rehabilitation by stating:

> With respect to the non-inpatient rehabilitation services . . . (detoxification, day rehabilitation, outpatient and community residence services) now being provided at three of the ATCs, it is the policy of the Division that they will be transferred when locally operated provider agencies are willing and able to sponsor them at the same high quality of care.[28]

Table 6

Projected and Actual Admissions
for Inpatient Rehabilitation
1981-82 and 1982-83

Center	1981-82 Actual Admissions	1982-83 Projected Admissions	1982-83 Actual Admissions	Difference
Bronx	127	160	156	-4
Buffalo	359	379	389	+10
Central Islip	418	643	414	-229
Creedmoor	185	212	182	-30
Kingsboro	130	174	149	-25
Manhattan	517	560	602	+42
Marcy	493	532	540	+8
Middletown	168	248	223	-25
Rochester	346	428	395	-33
Rockland	369	369	391	+22
St. Lawrence	271	309	298	-11
South Beach	197	227	238	+11
Willard	268	266	286	+20
Total	3,848	4,507	4,263	-244

Source: DAAA, Systemwide Program Plans for State Operated Alcoholism Services, December 1982 and Local Services Statistical Reporting System (LS-2C), July 13, 1983.

The plan gives the expected dates for transfer of these services:

Center	Service	Expected Date of Transfer
Central Islip	Day Rehabilitation	3/31/83
Rochester	Day Rehabilitation	3/31/83
Marcy	Day Rehabilitation	1982-83
Central Islip	Detoxification	3/31/84
Rockland	Detoxification	3/31/84
St. Lawrence	Detoxification/Sobering-Up	1982-83
Rockland	Outpatient/Clinic	3/31/84
Central Islip	Community Residence	1984-85

With the transfer of these service components to local providers it is expected that rehabilitation bed capacity for the entire State operated alcohol services will increase from 498 beds to 548. The increases in capacity will occur at Central Islip (21 beds), Rockland (19 beds) and Marcy (10 beds).

DAAA provided LCER staff with a status report on the transfer of other than inpatient rehabilitation services as of May 5, 1983. The Central Islip day rehabilitation and the Marcy day treatment program were phased out by March 31, 1983 which is in accordance with DAAA systemwide goals. The Marcy day treatment program clients were referred and transferred to Oneida County Alcoholism Services which has established a day rehabilitation program. The Rochester day rehabilitation program had not been transferred although DAAA has identified several programs in the Rochester area (Health Association and Jordan Community Health Center) which may be suitable providers once these programs are funded and become operational.

None of the detoxification units had been transferred from Rockland, St. Lawrence and Central Islip. The status of these transfers and the Article 28 applications to the Department of Health were discussed earlier.

The Rockland outpatient clinic at Mount Vernon had not been transferred as of May 5, 1983 although Westchester Community Opportunity Program has been identified as the sponsor. The application for certification by DAAA has been developed through the Westchester County Department of Mental Health and the tentative transfer date is for the fall of 1983.

DAAA has no current plans to transfer the community residence program at Pilgrim, nor has a sponsor been identified although it is targeted for transfer in fiscal year 1984-85.

Five Year Plans of DAAA, the Counties and the City of New York

Section 5.07 of the Mental Hygiene Law establishes the State planning process for alcoholism services by stating:

> There shall be a statewide comprehensive five-year plan for the provision of all state and local services for the mentally ill, mentally retarded and developmentally disabled, and those suffering from alcoholism and substance abuse . . . The commissioners of each of the offices shall be responsible for the development of the portion of such statewide five-year plan for services within the jurisdiction of their respective offices . . .[29]

In addition, Section 5.07 establishes the Council for Mental Hygiene Planning (CMHP) to develop statewide goals and objectives to guide comprehensive planning, resource allocation, and evaluation processes for State and local services. The 19 member Council is appointed by the Governor and includes the heads of the offices and divisions serving alcoholics, substance abusers, the mentally ill, the mentally retarded and developmentally disabled.[30]

Local Services Planning Process

Section 41.16 of the Mental Hygiene Law requires DAAA to guide and facilitate the process of local planning for alcoholism services so that plans for the provision of all services provided under the Mental Hygiene Law, including State and local services will be formulated on the basis of regional needs and resources. The Five Year Comprehensive Plan for Alcoholism Services (December 1978) states:

In accordance with regulations for planning alcoholism services established by DAAA, each county and the City of New York is to:

--Administer a local comprehensive planning process, which involves service providers, consumers and consumer groups, for the development of a five-year plan for alcoholism services for its geographic area;

--Establish long-range goals and objectives for the development of local alcoholism services which are consistent with statewide goals and objectives developed by the Council on Mental Hygiene Planning;

--Develop or annually update the local plan; and

--Submit the updated plan annually to the State.[31]

According to the 1982 Update of the Five Year Comprehensive Plan, the purpose of a local government plan is to construct a comprehensive picture of the total spectrum of existing and planned alcoholism services within the area served by that local governmental unit regardless of funding sources. The local planning process starts in February of each year with the development and distribution of the Local Governmental Unit Plan Guidelines and the Uniform Budget Report (UBR) forms. Counties have three months to complete their local plans and budgets and return them to the Inter-Office Coordinating Council for distribution to the appropriate offices and divisions of the Department of Mental Hygiene.

Upon receipt of the local plans, DAAA starts a comprehensive review and analysis. The results of this analysis form the basis for DAAA's long-range planning and production of the State Plan Update by October first of each year. The information submitted to DAAA by the State's 58 local governmental units, 57 counties and the City of New York (five boroughs), concerning the size and characteristics of the current alcoholism services system is supplemented by the Monthly Statistical Reporting System (LS-2C) and the semi-annual Uniform Budget Report Submissions. The 1982 Update stated that "the incompatibility of program information remains a problem, regarding the reporting of information in the local governmental unit plans, the UBR and the LS-2C systems."[32] Nevertheless, DAAA was able to determine, as part of its 1982 Update, that 209 local agencies operate 413 programs statewide, and it determined the distribution of these alcoholism services by the region of the State in which they were located.

DAAA Estimation of Bed Need

The first step taken by DAAA in estimating the number of beds needed in New York State for alcoholism rehabilitation and detoxification was to estimate the prevalence of problem drinkers in the State. In 1981 DAAA adopted a basic prevalence estimating methodology which utilizes the results of the Cahalan et al. National Survey of American Drinking Practices which classified drinking based on quantity, frequency and related problems into the following categories: abstainers, light, moderate and heavy drinking; and heavy escape drinker (problem drinker). Unpublished data from the Cahalan National Survey for the Mid-Atlantic Region of the United States were examined along with research by Keller, Jellinek, Kittredge, Marden and DAAA's Research Institute on Alcoholism.

DAAA updated its original estimates of problem drinkers in 1982 using final U.S. Census figures and found:

--there are 1,191,262 problem drinkers in New York State or 9.3 percent of the State's population age 18 and over or 6.6 percent of the State's total general population.[33]

In January 1982 DAAA obtained 1980 county specific U.S. Census data which allowed for an application of the age/sex prevalence estimating technique to the State's 62 counties. The estimates for problem drinkers by county were determined by applying a percentage factor to each county (which was not the same as the 9.3 percent applied statewide). The percentage factor was based on unpublished data from the Cahalan National Survey for the Mid-Atlantic Region of the U.S. and the Kittredge study, "Alcoholism and Alcohol Abuse in North Carolina, Estimates of Need."

After estimating the number of problem drinkers and alcoholics in New York State, the next step was to estimate the number of persons who can be expected to need inpatient rehabilitation and detoxification services in each county at any given point in time. The estimates of the target population and beds needed were determined by DAAA as follows:

--DAAA chose an interim planning goal of providing a comprehensive network of services to 20 percent of the estimated problem drinker population in need.

--The clinical need for short-term inpatient rehabilitation is estimated at 12 to 15 percent of the persons to be treated annually. Twelve percent is used in densely populated service areas or parts of service areas which have the potential for development of a range and variety of intensive ambulatory programs. Fifteen percent is used in other areas where access to a range and variety of programs cannot be expected to be provided. Although a distinction is made in two types of service areas in the 1981 Update, DAAA used the 15 percent target population figures in estimating bed needs.

--The average daily census must be computed to determine bed need. The average daily census is the target population multiplied by the planning goal of an average length of stay of 25 days, divided by 365 days.

--The final step in determining bed need estimates is to divide the average daily census by 90 percent occupancy.

The calculation for estimating bed needs for detoxification is similar to the above methodology except the planning goal is an estimate of the population addicted to alcohol. The 1981 Update states "it is assumed that approximately one-half of this estimate [total problem drinkers] have become addicted to alcohol."[34] A planning goal of a five day average length of stay and an average occupancy rate of 85 percent are used in the calculation of bed needs.

Table 7 shows the results of applying the DAAA bed need estimating methodology to the estimate of problem drinkers by region and the total for the entire State. As the table shows, the needs estimated are for the New York City region (1,102 beds), the Long Island region (404 beds) and Upstate (1,214 beds). The total statewide bed need for 1982 is shown below:

	Beds Needed	Beds Available	Gap
Inpatient Rehabilitation	2,720 (100%)	1,145 (42%)	1,575 (58%)
Inpatient Detoxification	1,440 (100%)	681 (47%)	759 (53%)

Application of the bed need methodologies for the entire State, indicate that 42 percent of the inpatient rehabilitation bed need has been met and 47 percent of the inpatient detoxification need has been met. However, the DAAA 1982 Update of the Five Year Plan indicates that applying the methodology at the regional level may be difficult because an accurate determination of the service areas of existing providers of inpatient rehabilitation and detoxification may not be available. The 1982 Update states:

> Updated patient origin data on other than State-operated facilities for statistically accurate sampling periods is largely non-existent. This information becomes important particularly for those facilities whose service areas cross regional and State planning boundaries. These facilities should only have a portion of their total number of beds counted towards filling regional needs of the area in which they are physically located.[35]

Table 7

DAAA Bed Need Estimates for Inpatient Rehabilitation Beds Based on 1980 Census

Category	Long Island	New York City	Upstate	Total
Problem Drinkers	176,892	482,877	531,493	1,191,262
Planning Goal (20% of Problem Drinkers)	35,378	96,575	106,299	238,252
Rehabilitation Target Population (15% of Planning Goal)	5,307	14,486	15,945	35,738
Average Daily Census (Rehab. Target Pop. X 25 Days÷365)	363	992	1,093	2,448
Bed Need Estimate (at 90% occupancy)	404	1,102	1,214	2,720

Source: DAAA, Bed Need Methodology for Inpatient Rehabilitation, May 4, 1983.

The 1982 Update also cites the need for updating and reviewing the inpatient bed need as services are developed to meet the need by stating:

> Experience, especially in regard to utilization, will be a major factor in determining future revisions. As programs become available to serve geographic areas, it will be necessary to determine whether waiting lists and excessive travel time to obtain care continue to exist. It will also be necessary to review service utilization patterns, independent of the abuse conditions, and to determine the impact on the development of needed outpatient alternatives. Experience will also be necessary to determine program effectiveness in producing long-term sobriety and to determine optimum lengths of stay in inpatient settings during a course of treatment.[36]

DAAA's Promotion of Inpatient Rehabilitation Beds

DAAA's bed need methodology estimates the need for 2,720 inpatient rehabilitation beds statewide. LCER staff asked DAAA what steps have been taken to promote bed capacity for inpatient rehabilitation by community providers. DAAA responded by stating that it recognizes a definite need for the development of inpatient rehabilitation services; increases within the State ATCs will be limited and all other increases will occur in the local community. DAAA has identified the Albany, Binghamton, Syracuse and Southern Tier areas as regions where development is needed.

DAAA provided LCER with a list of proposed inpatient rehabilitation beds. In existing or new psychiatric, freestanding and general hospitals 220 beds are proposed (are pending DOH or DAAA approval or certification) for the Metropolitan New York City District, 218 beds are proposed for the Central District, and 159 beds are proposed for the Western District. Eighty beds have been proposed for the Albany area (Albany and Rensselaer counties) and 16 beds have been proposed for the Syracuse area. No new proposals for beds in Broome County have been submitted; however, United Health Services in Binghamton has recently begun an inpatient rehabilitation service consisting of 22 beds. An additional 50 rehabilitation beds will become available at State ATCs when detoxification services are transferred.

A problem which DAAA has identified in promoting inpatient rehabilitation beds is the lack of funding for hospitals for alcoholism treatment beds. The 1982 Update of the Five-Year Plan states that "medicare, medicaid and insurance coverage are largely unavailable to freestanding facilities, and the cost of care means that only a relatively few persons can pay all or most of the cost directly."[37] The DAAA District Director for New York City said that DAAA encourages voluntary and public hospitals to set up rehabilitation units. However, proprietary hospitals cannot take Medicaid patients because of certain Medicaid regulations.

Continuum of Alcoholism Services in Selected Regions

According to the 1982 Update of the Five-Year Comprehensive Plan, DAAA has determined that the system of treatment services for alcoholism should include: sobering-up services, inpatient detoxification, alcoholism clinic services, community residences and day rehabilitation services. Currently only seven of the State's 62 counties have the desired range of alcoholism programs.[38]

Chart 2 shows the continuum of services a client would typically require from the point of entrance to the system through a referral by a community agency or self-referral to aftercare service which aid in the maintenance of sobriety. As the chart shows, a client with an alcohol problem is usually referred to either sobering-up services or medical detoxification. Sobering-up stations are intended to offer temporary protective care to intoxicated persons and are usually staffed by nurses or other paramedical personnel who are trained to observe symptoms of alcohol withdrawal and other related medical problems. Detoxification services differ from sobering-up in that the client is typically suffering from acute alcohol withdrawal symptoms which require medical attention. The length of stay for sobering-up is usually 24 to 48 hours and five to seven days for detoxification. A client who is sobering-up and who exhibits signs of alcohol withdrawal which requires medical attention will usually be referred to a medical detoxification unit or hospital emergency room.

After a client has sobered-up or has been detoxified from alcohol, he or she is usually referred to outpatient treatment, inpatient rehabilitation or aftercare services (A.A., halfway house, counseling or job referral) depending on the severity of the individual's alcohol problem. After outpatient treatment or inpatient rehabilitation the client is referred to aftercare services which will aid the individual in the maintenance of abstinence.

Chart 2 shows the ideal continuum of services in the treatment of an alcoholic client; however, many clients leave the system before treatment is complete and may become "repeaters" at any stage in the continuum upon returning to the system. In addition, many regions of the State may be lacking one or more services in the continuum.

LCER staff visited each type of services in the continuum (sobering-up, detoxification, county agencies, outpatient rehabilitation, community residences and inpatient rehabilitation) in the Marcy, Central Islip and Manhattan ATC service areas to determine:

--The availability of services in the continuum to alcoholic clients in these service areas,

--What role the State ATCs play in providing services in these areas and,

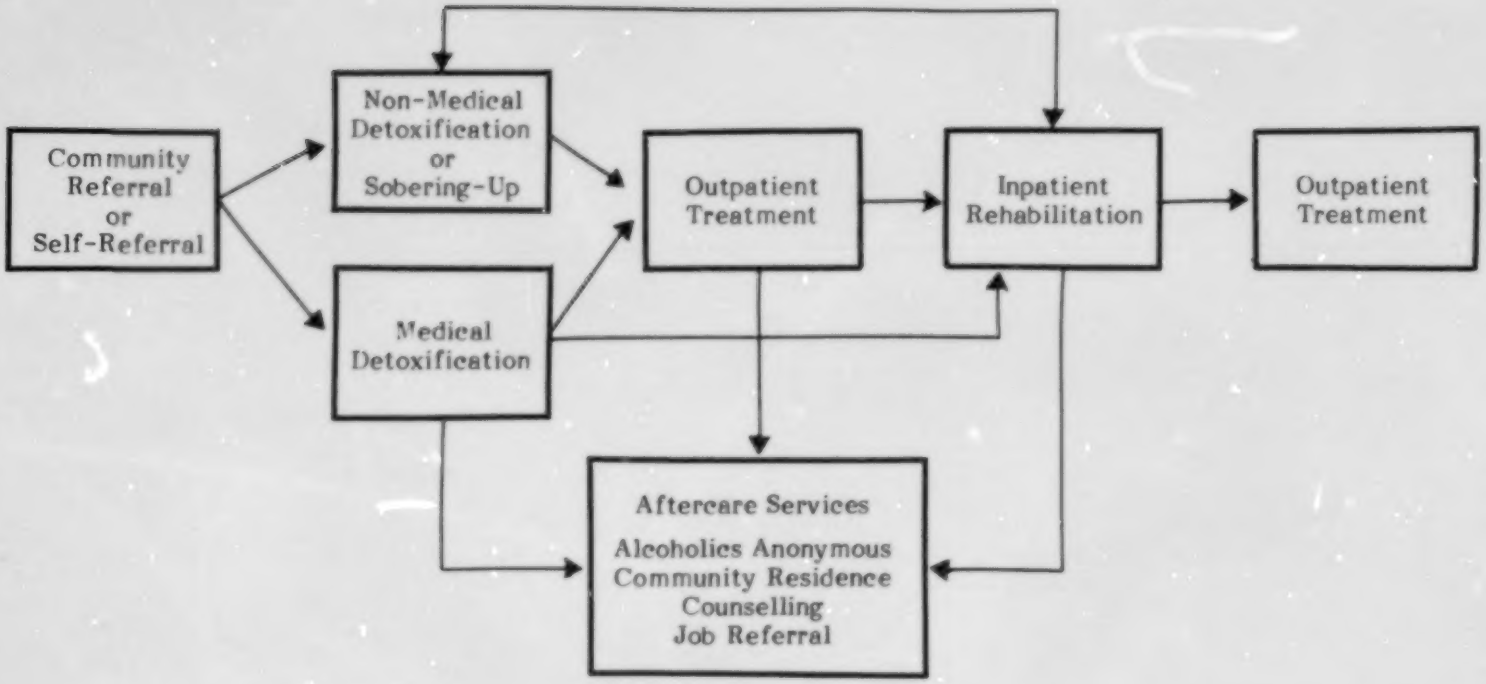
--The degree of coordination between the State facilities and community providers in these three regions of the State.

Most all of the community providers visited by LCER staff indicated that the availability of beds at Marcy (waiting period) is the most important factor in making referrals to Marcy. The Director of the Albany Citizen's Council on Alcoholism Sobering-Up Center stated that prior to June 1983 the Sobering-Up Center had difficulty referring clients to Marcy because of the long waiting period (clients were waiting three to four weeks and up to three months in January 1983). He stated that the sobering-up unit was losing clients because it is unable to hold patients for an extended time period. The Director of the Alcoholism Center of Rensselaer County told LCER staff that a client may wait up to two weeks to get into Marcy and during this waiting period may return to drinking or decide not to enter inpatient rehabilitation.

Although the majority of community providers felt that the waiting period to get into Marcy is a problem, Marcy ATC stated that it does not have a waiting list and the average wait is five working days. Marcy said that the referral agencies keep a record of who is waiting and make the appointments for screening. Marcy contacts the referral agency 48 hours before the client is due for admission to confirm the client's appointment.

Chart 2

Continuum of Services*



*At any point after referral, a client may choose to leave the flow of services and return to drinking.

Source: LCER Staff, June 1983.

Therefore, the Marcy waiting list only has those patients who are to be admitted in the next two days.

In the Central Islip service area the greatest problem in coordination of services appears to be between Central Islip ATC and the sobering-up stations. Although the occupancy rate at Central Islip was the lowest of any ATC in 1981-82 and 1982-83, during visits by LCER staff to the Talbot House Sobering-Up Station in Suffolk County and to the Nassau County Department of Drug and Alcohol Addiction the following statements were made:

--At Talbot House it was stated that for patients referred to Central Islip rehabilitation the waiting time may vary from one day to one week.

--At the Nassau County Department of Drug and Alcohol Addiction it was stated that nine of 22 beds at the sobering-up station were designated as holding beds, an arrangement approved by DAAA.

LCER staff asked DAAA, why, in view of the low occupancy of rehabilitation beds at Central Islip, it should be necessary to hold patients who are referrals for rehabilitation at the two sobering-up stations in Nassau and Suffolk counties. DAAA responded by stating:

> . . . last year, the C.K. Post ATC [Central Islip] and Talbot House Sobering-Up Station took steps to improve the referral linkage between their services, which have resulted in a smoother flow of patients and increased utilization of both programs. The recent waiting period issue raised by Talbot House is a temporary and legitimate concern. The staff of the ATC reviewed the requests for admission from Talbot House since April 1, 1983 and found that the average waiting period was one (1) day through May 31; from June 1 to August 18, the wait was nine (9) days on the average, the result of the relocation (of Central Islip to Pilgrim) and eleven (11) staff retirements for which replacements are being held under the state hiring freeze. Ms. Santiago (Director of Pilgrim ATC) has indicated that the number of weekly admission interviews is being stepped-up to among other things reduce the waiting time. Concerning the Nassau holding beds . . . this service provides an important structured and alcohol-free program environment. It is utilized by the sobering-up service . . . to "hold" patients for a number of reasons, including those individuals awaiting admission to an inpatient rehabilitation program or community residence, and those for whom housing arrangements are being finalized. The scheduling patterns for screening and admission has made some degree of waiting a reality prior to inpatient admissions.[39]

DAAA stated that the cost of the holding beds in 1982 was $111,600 for the State and $27,900 for Nassau County. Projected expenditures for 1983 are $90,635 for the State and $48,825 for Nassau County. The cost per day per patient for 1983 is projected by DAAA to be $50.

In the Manhattan service area there appears to be a full range of services for alcoholics and no waiting problem at Manhattan ATC; however, there may be a lack of coordination in referrals from sobering-up and detoxification to the State ATCs. The Director of the Bowery Residents Committee Sobering-Up Station told LCER staff that only four percent of all patients they saw in 1982 were referred to State ATCs. Most all

of the clients who were referred showed up at the ATC excluding those who left the sobering-up station against medical advice.

In addition, figures provided by the Manhattan Bowery Corporation which operates a 35 bed non-medical detoxification program, show that it refers only a few clients to State ATCs. From a total of 366 referrals from January 1983 to April 1983, only 12 clients or three percent were referred to a State ATC (Manhattan, Creedmoor and Central Islip); three of these clients were accepted into treatment and nine clients did not show up for admission.

Alcoholism Treatment Effectiveness

DAAA Research Institute on Alcoholism Outcome Study

DAAA's Research Institute on Alcoholism conducted a two year study from July 1976 to August 1978 which attempted to analyze the effectiveness of alcoholism rehabilitation. A follow-up study was done using 1,340 clients from 14 State ATCs and three community providers. All cooperative clients admitted during the six month period from April to September 1977 were followed-up and interviewed (mail survey) two and six months after their discharge from treatment. Clients were questioned on their socioeconomic status, social stability, treatment history, quantity of alcohol consumed, degree of impairment (e. g., drinking alone, blackouts and missing work), financial status, social adjustment, drug abuse, and abstinence before and after treatment. The completion rates for the study were 71 percent at two months and 67 percent at six months after discharge.

The basic findings of the study showed:

--Overall, the percentage of abstinent clients increased from six percent before treatment to 65 percent at two months and 61 percent at six months. The six percent who were abstinent before treatment were those who were in some other institution or those who were maintaining abstinence while waiting for admission.

--Those clients who were drinking at the time of follow-up were found to be drinking less heavily than they were before entering treatment.

--There is a tendency for those clients who were in treatment longer to include a higher percentage of abstainers, but length of stay had an insignificant effect on the quantity of alcohol consumed if a client was drinking after discharge.

The results of this study suggest that the State alcoholism treatment centers are effective in treating alcoholics (measured by abstinence) and that the longer a client remains in treatment the better his chances are at remaining abstinent after discharge from treatment. However, the conclusiveness of this study in regard to the present operation of the State ATCs needs to be examined. The study was completed in 1978 and in a five year period (1983) there may be a need for a more current update considering changes which may have occurred in ATC policies such as shorter lengths of stay.

Problems in Client Follow-Up

The Research Institute's outcome study states "the most difficult aspect of data collection was the follow-up phase. Locating clients who left treatment two and six

months prior to the follow-up interview posed a major problem in the cases of clients who had changed their residence from the time they left treatment."[40]

The follow-up interviews were completed in three stages and relied heavily on the recovered alcoholics' self-reported data. In the first stage a client was sent a mail survey. If a client did not return the survey, an interviewer was responsible for tracking the client in a specific geographic region. If the interviewer was still unsuccessful, a telephone interviewer at the Research Institute attempted to reach respondents and conduct a telephone interview.

Voris, in his study "Alcohol Treatment Outcome Evaluation," cited studies in which the validity and reliability of self-reported data from alcoholics were examined.[41] One study reported that a comparsion of official records with self-reports of arrests for public drunkenness and driving while intoxicated indicated that these self-reports were reliable, particularly if clients knew that answers would be used in decision making relative to their treatment programs. Another study cited by Voris recommended several strategies to enhance the validity of self-reports. Information on the client at follow-up, if possible, should be collected from official information sources, with any significant discrepancies discussed with the client. Also suggested was the promotion of positive consequences for reporting drinking behavior and monitoring patients to assure they are not intoxicated when giving information.

The use of the mail survey and telephone interview by the Research Institute, while the most cost effective means of surveying, precludes the possibility of assuring that the client is not intoxicated at the time of follow-up.

State ATC Methods of Follow-Up

DAAA told LCER staff that all ATCs are expected to follow-up clients after discharge and provide referral to aftercare. LCER staff asked the ATCs to indicate how effectiveness is measured after clients are released; what methods are used in collecting follow-up data; and what criteria are used to measure abstinence, level of alcohol consumption or other success criteria.

LCER staff found that Rochester, Marcy, Rockland and Kingsboro do not do formal follow-up studies to determine effectiveness of treatment. Central Islip has no on-going method of follow-up and completed only a short-term study in November 1982 which looked at abstinence at two, six and 12 months. Willard also does not have regular follow-up, but conducted a survey in September 1981 which was sent to referral agencies only and collected data on the number and type of agency contacts, the clients' level of substance and alcohol abuse and the number of alcohol arrests.

The remaining ATCs all have some form of on-going follow-up. LCER staff found there is no consistency in the time intervals used although all of the ATCs used a mail survey to follow-up on clients and the criteria for effectiveness used were abstinence and quality of life (i. e., employment status, AA attendance, drug use and medical problems). St. Lawrence and Bronx ATCs had the most comprehensive methods of follow-up and analysis of results.

St. Lawrence Follow-Up

St. Lawrence provided LCER staff with a summary of its outcome study for 1981. A total of 346 surveys were mailed to discharged clients and 252 were returned (73 per-

cent); 77 percent of the two month surveys were returned; 73 percent of the six month were returned; and 66 percent were returned after 12 months.

The questionnaires used by St. Lawrence are in-house designed. The questionnaire asks clients to indicate the length of their present sobriety, the longest period of sobriety since discharge, the number of relapses, and a rating of life improvement since treatment at St. Lawrence.

As a result of the St. Lawrence outcome study for 1981 it was found that:

--St. Lawrence discharged 133 patients to aftercare or 44 percent of the total patient population admitted. Of the 133 aftercare patients, 84 percent were first time admissions to treatment. Of the 21 patients who were readmissions, 29 percent were abstinent 12 months after discharge.

--Of the 133 patients including the readmissions who were discharged to aftercare 35 percent or 46 were abstinent after 12 months.

--Of the 305 patients admitted for treatment during 1981, 46 or 15 percent claimed total abstinence from alcohol 12 months after their discharge.

From the results of the St. Lawrence outcome study it appears that treatment in this State alcoholism treatment center is effective in treating some alcoholics considering that over one-third of all patients discharged remained abstinent after 12 months. Data from the survey also imply that most St. Lawrence patients who abstain for at least one year after discharge from treatment continue to receive support (from family, counselors or AA), have activities to keep them productive each day, and have spent an above average length of stay in treatment of 51 days. St. Lawrence's finding on length of stay concurs with the Research Institute's conclusion that a longer stay in treatment produces a greater percentage of abstainers.

Bronx ATC Follow-Up

Bronx ATC carries out a follow-up process similar to St. Lawrence. Effectiveness of treatment is measured by collecting aftercare data from clients at two weeks, one month, three months, six months, nine months and 12 months after discharge. The contacts with discharged clients are made by a telephone call to the client, by a visit by the client to the ATC, by a visit with the client at aftercare agencies, by mail or by information conveyed from outpatient counselors.

Bronx ATC said that in measuring abstinence, if a person drank even once during the three, six or 12 month periods he or she is counted as not being sober. This standard does not allow for the client who may have a brief "slip" and then either stops drinking on his own or enters detoxification and begins a new period of abstinence. Bronx found that a significant number of clients described as not being sober fall into the category.

During the one year period from June 1, 1981 to May 31, 1982, 127 clients were admitted to Bronx ATC and 80 clients completed treatment and were followed-up. In summary Bronx found:

Abstinent	3 Months	6 Months	12 Months
Yes	47	31	16
No	12	6	5
Unknown	21	43	59
Total	80	80	80

Bronx ATC had much greater difficulty tracking clients for follow-up than St. Lawrence. In response to this problem Bronx stated:

> Most of the information is obtained by one or two staff members who have a full clinical load but who gather this information as time permits . . . our clients tend to be transient, poor and not easily accessible over a year's period of time. Therefore, the declining figure for sobriety over the year does reflect social situations beyond the control of the program. Likewise there is a large number of clients who are no longer easily available to us and their current level of functioning is unknown.[42]

Chapter Summary

- In 1982-83 there were 6,714 admissions to the 13 State operated alcoholism treatment center services (inpatient rehabilitation, detoxification and community living) or less than one percent of the estimated 1,191,262 problem drinkers in New York State. Actual admissions were six percent less than projected in DAAA's Systemwide Program Plans. Central Islip showed the greatest difference in admissions with actual admissions in 1982-83 229 less than projected.

- The expected occupancy rate for all rehabilitation becs at ATCs in 1983 was 86 percent. However in 1982-83 Central Islip ATC had the lowest occupancy rate at 53.5 percent. Rockland ATC was operating above capacity in 1982-83 with a 115.6 percent occupancy rate.

- Clients served by the State ATCs, especially those in the Metropolitan New York City area, have drinking problems compounded by high unemployment, inadequate education, poor work history, family instability, social isolation and inadequate housing.

- The Mental Hygiene Law requires that no person be denied treatment and services because he or she suffers from more than one disability. Most ATC admission policies on multi abusers of alcohol and hard drugs do not conform to the law. Studies by the U.S. National Institute on Drug Abuse and the Department of Mental Hygiene's Inter-Office Coordinating Council found that a significant number of multi abusers (combination drug and alcohol abuse) exist. However, none of the 13 ATCs admit patients who are using hard drugs such as heroin and eight of the ATCs will not admit anyone using drugs of any kind. Rochester is the only ATC which accepts clients to rehabilitation who are on methadone maintenance.

- Although the dangerous side effects of the drug, disulfiram, have been documented at Manhattan ATC, DAAA has no overall policy governing the use of disulfiram in State ATCs. Disulfiram is used in all of the State ATCs except and Middletown, and the use of this drug is a mandatory criterion for admission at Creedmoor ATC.

- Most of the State ATCs were dissatisfied with Office of Vocational Rehabilitation services to recovered alcoholics due to OVR's eligibility requirement that alcoholic clients be abstinent for six months prior to receiving OVR services. OVR reported that this requirement does exist but acceptance of referrals not meeting the six month sobriety period may be considered at the discretion of the OVR Area Office Manager.

- As of August 1983, detoxification services were being provided to alcoholics at Pilgrim, St. Lawrence and Rockland ATCs although it is a goal of DAAA to transfer this service to local sponsorship. General hospitals have been identified for all three detoxification units but transfers are pending the submission and approval of Department of Health Article 28 applications or establishment of scatter bed services at two hospitals.

- DAAA estimated the need for 1,102 inpatient rehabilitation beds for the New York City region, 404 for the Long Island region, and 1,214 for Upstate. Statewide 42 percent of the inpatient rehabilitation bed need and 47 percent of the inpatient detoxification bed need have been met. DAAA has identified the Albany, Binghamton, Syracuse and Southern Tier regions as areas where development of beds is needed; 220 hospital beds are proposed for the Metropolitan New York City District; 218 beds are proposed for the Central District; and, 159 are proposed for the Western District. These 597 proposed beds plus 50 beds converted by DAAA to rehabilitation would equal 647 of the gap of 1,575 beds DAAA estimates are needed for rehabilitation. Still needed would be 928 beds.

- Community providers in the Marcy ATC service area (Upstate) had difficulty referring clients to Marcy because of long waiting periods for up to four weeks yet Marcy ATC does not have a waiting list and reported an average wait of five working days.

- Clients are held in sobering-up stations in Nassau and Suffolk counties before admission to inpatient rehabilitation despite the low occupancy at Central Islip ATC. The cost of holding beds in 1982 was $111,600 for the State and $27,900 for Nassau County. DAAA reported that the holding of patients is necessary due to scheduling patterns for screening and admissions and waiting for admission to inpatient rehabilitation or community residences.

- Comprehensive follow-up of clients discharged from State ATCs is done at St. Lawrence and Bronx ATCs. The results of the St. Lawrence outcome studies indicate that treatment in this State ATC is effective in treating some alcoholics as evidenced by the abstinence of over one-third of the discharged clients at 12 months.

- The follow-up data on patients released from ATCs other than Bronx and St. Lawrence are inadequate to judge how the patients fared after leaving the centers. More comprehensive and consistent follow-up studies and experimental programs would give DAAA a better basis for deciding when to use outpatient versus inpatient treatment and how long a client should stay in inpatient rehabilitation.

- The Research Institute on Alcoholism has not conducted follow up studies of patients released from the ATCs during the past five years.

III MONITORING

The programs and physical facilities of the 13 State alcoholism treatment centers are monitored by the Joint Commission on Accreditation of Hospitals (JCAH) and by the State Division of Alcoholism and Alcohol Abuse. This chapter reviews the scope and results of this monitoring.

Joint Commission on Accreditation of Hospitals (JCAH)

JCAH was formed by the American College of Physicians, the American Hospital Association, the American Medical Association, and the American College of Surgeons to accredit hospitals. OMH has sought JCAH accreditation for each of its adult psychiatric centers. DAAA has sought separate accreditation for each of its alcoholism treatment centers. If a center or program lacks accreditation it loses its reimbursement from the federal government for patients eligible for Medicare or Medicaid. It also loses its resident physicians who are training in their medical specialties. If a State alcoholism treatment center receives accreditation but the State psychiatric center in which the alcoholism treatment center is located does not receive accreditation then the alcoholism treatment center still loses reimbursement from the federal government for patients eligible for Medicare or Medicaid.

In order to receive accreditation, both OMH psychiatric centers and DAAA alcoholism treatment centers must meet the JCAH Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism and Drug Abuse Programs. These cover program management, patient management, physical plant management, and patient services. This is the only independent monitoring of State alcoholism treatment centers.

Psychiatric Centers

From July 15, 1981 to May 28, 1983 Manhattan Psychiatric Center lost its JCAH accreditation. During this period no Medicaid or Medicare funds could be collected on behalf of patients in the Manhattan Alcoholism Treatment Center (or for that matter on behalf of psychiatric patients at Manhattan).

Alcoholism Treatment Centers

As of June 1983 all 13 State alcoholism treatment centers had current JCAH accreditation for their programs. One was for one year -- Rockland; nine were for two years — Bronx, Buffalo, Kingsboro, Marcy, Middletown, Rochester, St. Lawrence, South Beach, and Willard; three were for three years -- Creedmoor, Manhattan and Pilgrim (Central Islip).

NYS Division of Alcoholism and Alcohol Abuse

There are two types of monitoring of the State alcoholism treatment centers provided by the parent agency, DAAA: pre-JCAH inspections and site visits. DAAA and OMH management information systems compile data from the alcoholism treatment centers which can serve as a management tool for monitoring.

Pre-JCAH Inspections

Prior to the scheduled date of a JCAH inspection, DAAA sends a team of its own into each State alcoholism treatment center to see whether JCAH standards are being adhered to. Deficiencies noted are corrected prior to the JCAH inspection, if possible.

Site Visits

Annual monitoring and technical assistance site visits to State alcoholism treatment centers began in 1982. They were based on a Site Visit Protocol prepared by the Deputy Director of DAAA responsible for the operation of the centers. The purpose of these visits by DAAA personnel is:

> ...to foster and maintain the highest quality of alcoholism services within the limited resources available, and to continuously assess and propose programmatic designs and techniques to enhance the efficiency and effectiveness of each program as well as the alcoholism services system. ...Care must be taken not to duplicate the work of DAAA's certification staff except to follow-up, with their concurrence, on conditions of the operating certificate.[1]

The persons from DAAA who make the site visits usually include the Coordinator of the State Alcoholism Treatment Centers, a Director from another State alcoholism treatment center, the District or Regional Director where the center is located, and personnel from the DAAA central office.

Under the Site Visit Protocol the areas to be covered are client services including a review of client records, staff and staff training, planning and evaluation, management, certification, continuity of care, community relations and fiscal matters. A review of the site visit reports made in 1982 indicates:

--All 13 centers were visited and a report prepared on each based on one-day visits. The site visitors met with the center director and other key staff.

--The areas required to be reviewed in the Site Visit Protocol which were covered in the reports included a review of client records, staff, planning, continuity of care and community relations. Certification and fiscal matters were not covered in the site visit reports. The Site Visit Protocol, however, required these to be included.

--Examples of recommendations made in the Site Visit Reports include: developing goals and objectives specific to each patient, increasing the number of beds by giving more priority to patient area over staff area, carrying out vocational assessments of patients, addressing low occupancy, using patient wardrobes to increase privacy, developing specific criteria for the review of extended length of stay, developing evaluation studies of the effectiveness of treatment, making an affirmative action plan for hiring minority group staff, and referring all patients to Alcoholics Anonymous before discharge.

LCER staff, in making visits to the 13 State alcoholism treatment centers, prepared their own questionnaire to which the centers responded. The Site Visit Reports were useful background information.

Fiscal Monitoring

DAAA fiscal personnel, using reports from the State Department of Audit and Control and from fiscal officers in the State psychiatric centers, maintain normal expenditure and fiscal controls during the budget year.

OMH prepares annual cost reports which show the total cost per patient according to detoxification, rehabilitation, and out-patient programs. The 1981-82 report is summarized in Chapter IV.

DAAA has a field audit staff of five which carries out fiscal audits of community providers. Fiscal audits by DAAA staff of the alcoholism treatment centers were requested by LCER staff but none were made available, with the explanation that none had been conducted.

Certification

The Mental Hygiene Law, Section 31.02, states:

> ...no provider of services shall engage in any of the following activities without an operating certificate issued by the commissioner (of mental hygiene) pursuant to this article: operation of a residential facility or institution, including a community residence for the care, custody, or treatment of the mentally disabled; ...

The Mental Hygiene Law in Section 1.03 (5) defines a "provider of service" as an "individual, association, corporation, or public or private agency, other than an agency or department of the state...." This has been interpreted to mean that DAAA's own State alcoholism treatment centers do not require operating certificates. As a result, the DAAA staff carrying out certification do not visit or inspect State alcoholism treatment centers. However, the Mental Hygiene Law, Section 19.07 (a) (7) states that the Director of DAAA:

> ...shall have the power to
> ...redefine and develop, establish, promulgate, and enforce certification, inspection, licensing, and treatment standards for alcoholism facilities and staff
> ...which shall be applicable to any facility providing or purporting to provide as part or all of a program of services, any services for the alleviation of the condition of alcoholism.

The Mental Hygiene Law in Section 1.03 (6) defines a "facility" as "any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution, or building..."

Thus, while the Mental Hygiene Law exempts the State alcoholism treatment centers from obtaining operating certificates it does give the Director of DAAA power to

promulgate and enforce standards applicable to any facility. The standards under which non-DAAA alcoholism facilities operate are in the Codes, Rules, and Regulations.[2]

These standards, among other things, require an operating certificate holder to obtain prior approval of a change in the maximum certified patient capacity of any facility; and to have an annual audit made of the facility's financial condition. DAAA has chosen not to apply these standards to its own treatment centers. Since none of them has had an annual financial audit, they do not meet the standards required of other facilities. DAAA reported to LCER staff that the Rockland Alcoholism Treatment Center in its rehabilitation unit operated at 115 percent of capacity in 1981-82 and 1982-83.[3] If Rockland had had to obtain an operating certificate it could not have legally been able to continue to operate over capacity. In short, DAAA has not applied all operating certificate standards to its own treatment centers. (See Appendix B, the agency response of DAAA, regarding DAAA's intention on future regulations.)

Management Information Systems

Both OMH, acting for the Department of Mental Hygiene, and DAAA compile statistics on patients in the State alcoholism treatment centers. The Department of Mental Hygiene Information System (DMHIS) includes data on census, admissions, diagnoses, legal status, client profiles, and releases. LCER staff during visits to the 13 alcoholism treatment centers compared the resident census reported by OMH in October 1982 with the Ward Journals maintained by DAAA personnel on the wards. There were substantial variances at Central Islip, Manhattan, Marcy and St. Lawrence. Because of compensating errors there was little difference in the total. It appeared that some alcoholism treatment centers had reported patients on leave as being in residence and some had not used the midnight census as required, causing OMH figures to be overstated.

	Average Number of Resident Patients-October 1982		
Center	OMH	Ward Journal	Difference
Bronx	20	20	0
Buffalo	21	22	+1
Central Islip	68	59	-9
Creedmoor	23	22	-1
Kingsboro	21	22	+1
Manhattan	58	49	-9
Marcy	52	58	+6
Middletown	24	25	+1
Rochester	30	31	+1
Rockland	47	49	+2
St. Lawrence	22	28	+6
South Beach	23	22	-1
Willard	23	23	0
Total	432	430	-2

The number of resident patients complied by OMH is needed for billing purposes so that only days in residence will be billed.

The DAAA management information system, called the LS-2C, receives monthly reports from both State alcoholism treatment centers and community providers, showing

patient days of resident and leave patients combined, admissions, discharges, and visits. Neither the OMH nor the DAAA management information system is capable of telling whether a patient discharged from a State alcoholism treatment center reports for and receives service from the community agency to which he or she is referred. Most of the community agencies are partly financed with State funds. The community agencies raise the issue of confidentiality of patient records. However, State agencies such as OMH and DAAA abide by State and federal regulations when treating patients in their own facilities and could do so with community agency records.

Chapter Summary

- As of June 1983, all 13 State alcoholism treatment centers were certified by JCAH. From July 15, 1981 to May 28, 1983 Manhattan Psychiatric Center lost its JCAH accreditation, which means no federal moneys could be received during those periods for Medicaid or Medicare eligible patients in alcoholism or psychiatric services.

- DAAA carried out site visits at each of the 13 State alcoholism treatment centers in 1982. The Site Visit Protocol was followed except with regard to certification and fiscal matters.

- While DAAA has its own fiscal field auditors, they have not audited the State alcoholism treatment centers.

- DAAA has not applied to its own alcoholism treatment centers all operating standards applicable to non-DAAA alcoholism treatment facilities. The Mental Hygiene Law empowers the Director of DAAA to enforce the certification, inspection, and treatment standards to any alcoholism facility.

- Neither the OMH nor the DAAA management information system is capable of telling whether a patient discharged from a State alcoholism treatment center reports for and receives service from the community agency to which he or she is referred.

IV FINANCES

This chapter reviews the costs, staffing, and revenues of the State alcoholism treatment centers.

Costs

The total costs[1] of the 13 State alcoholism treatment centers increased from $15.2 million in 1978-79 to $19.6 million in 1981-82. These include direct costs such as salaries, supplies and materials, indirect costs such as fringe benefits, depreciation, and bond interest; indirect costs of OMH such as utilities, dietary, and medical records; and ancillary costs for special services provided by OMH, such as radiology and dentistry. From 1979-80 to 1981-82 costs of detoxification services declined by $218,975, principally due to the closing of the detoxification unit at Rochester; the costs of rehabilitation have risen from $12.5 million in 1978-79 to $16.2 million in 1981-82; and the costs of outpatients have decreased from $731,824 in 1978-79 to $533,658 in 1981-82 (Table 8).

As late as September 1983, OMH was unable to supply cost figures for the 1982-83 fiscal year.

The detailed costs for 1981-82 are shown in Table 9 by alcoholism treatment center. The cost per patient day for detoxification ranged from $123 at Rockland to $395 at St. Lawrence. The cost per patient day for rehabilitation ranged from $54 at Rockland to $173 at South Beach. The larger centers such as Rockland and Marcy have lower costs per rehabilitation patient day while the smaller centers such as Bronx, Buffalo, Creedmoor and South Beach have higher per patient day costs. Part of the low cost per patient at Rockland is due to its operating over capacity.

	1981-82			
	Cost Per Patient Day		Patient Days	
Center	Rank (Low to High)	Amount	Rank (High to Low)	Number
Rockland	1	$ 54	3	12,961
Marcy	2	60	2	18,202
Kingsboro	3	106	7	8,442
Willard	4	108	6	9,228
Rochester	5	109	4	11,383
Manhattan	6	113	1	21,157
St. Lawrence	7	118	5	9,260
Middletown	8	122	9	7,625
Creedmoor	9	141	11	7,032
Bronx	10	150	12	6,913
Buffalo	11	152	8	8,419
South Beach	12	173	10	7,202

Because of the wide range of length of stay in rehabilitation from 24 days at Buffalo to 67 days at Kingsboro, the cost per patient stay ranged from $1,847 at Rockland to $8,167 at Bronx. The cost per patient detoxified ranged from $874 per stay at Rockland to $2,525 per stay at St. Lawrence.

Table 8

Total Cost of Alcoholism Treatment Centers
1978-79 to 1982-83

Service	Costs 1978-79	1979-80	1980-81	1981-82	1982-83
Detoxification	$ 1,994,220	$ 3,059,893	$ 2,741,223	$ 2,840,918	Not
Rehabilitation[a]	12,476,063	14,020,265	13,665,303	16,217,632	Available
Outpatient	731,824	851,014	463,444	533,658	
Total	$15,202,107	$17,931,172	$16,869,970	$19,592,208	

[a]Cost includes independent living at Central Islip.

Source: OMH, Reimbursement and Costing Services, August 2, 1983.

Table 9

Cost Per Patient Day and Per Stay
At State Alcoholism Treatment Centers
1981-82

Service and Center	Costs[a]	Patient[b] Days	Cost Per Patient Day	Average[b] Length of Stay in Days	Cost Per Stay
Detoxification					
Central Islip	$1,808,200	8,595	$210.38	4.2	$ 884
Rockland	694,610	5,641	123.14	7.1	874
St. Lawrence	338,108	857	394.53	6.4	2,525
Rehabilitation					
Bronx	$1,037,811	6,913	$150.12	54.4	$8,167
Buffalo	1,280,248	8,419	152.07	23.6	3,589
Central Islip	c		c		c
Creedmoor	988,968	7,032	140.64	40.0	5,626
Kingsboro	896,848	8,442	106.24	66.5	7,065
Manhattan	2,394,557	21,157	113.18	41.0	4,640
Marcy	1,570,230	18,202	86.27	37.6	3,244
Middletown	930,559	7,625	122.04	43.8	5,345
Rochester	1,236,440	11,383	108.62	32.3	3,508
Rockland	699,878	12,961	54.00	34.2	1,847
St. Lawrence	1,095,48[illegible]	9,260	118.30	34.2	4,046
South Beach	1,247,542	7,202	173.22	35.5	6,149
Willard	997,425	9,228	108.09	34.7	3,751

Sources: [a]*OMH, Bureau of Reimbursement and Costing Services, August 2, 1983.*
[b]*DAAA, Assistant Director, July 13, 1983.*
[c]*OMH did not divide costs between rehabilitation and community living at Central Islip.*

Staffing

On June 29, 1983 there were 166 persons employed by DAAA in its Albany and regional offices. Seventy out of the 166 were paid over $30,000 and were executives and specialists in alcoholism. This includes all programs of DAAA except the 13 State alcoholism treatment centers and the Research Institute on Alcoholism located in Buffalo.

The State alcoholism treatment centers employed 452 persons on June 29, 1983 including six extra service. In its Systemwide Program Plans for State Operated Alcoholism Services, dated December 1982, DAAA stated that its goal is to employ 477 persons in these centers including 441 for existing rehabilitation beds, four for the existing 19-bed independent living unit at Pilgrim and 32 persons to increase the number of rehabilitation beds from 498 to 548 when detoxification beds are closed at Pilgrim and Rockland and staff reassigned from detoxification to rehabilitation. The increases in rehabilitation beds and assigned staff would be:

Treatment Center	Proposed Increase in Rehabilitation Beds	Proposed Increase in Rehabilitation Staff	Staff Per Added Bed
Marcy	10	4.5	.45
Pilgrim	21	16.0	.76
Rockland	19	13.5	.71
Total	50	34.0*	.68

*This is the total of increased staff recommended by DAAA for added rehabilitation beds and is two more positions than stated in the summary of the same DAAA report.

The additional 21 rehabilitation beds at Pilgrim can not be justified based on the fact that the existing 79 rehabilitation beds were only 53.5 occupied in 1982-83. The rehabilitation beds at Marcy were 93.8 percent occupied and those at Rockland 115.6 percent occupied in 1982-83.

Revenues

OMH was unable to provide any information on how much was collected on behalf of patients at State alcoholism treatment centers prior to March 31, 1983. The reasons given were:

> . . . the revenue information is not available in the format specified. The following description of the Office of Mental Health (OMH) billing system will explain why.
>
> When a full cost bill is produced in the OMH system, the charges are based on the number of days the patient is in the particular cost center multiplied by the charge for that cost center. If a bill is to be produced at less than full cost, the charges are based on the number of days the patient is in the cost center multiplied by the rated charge. When payments are received on an account, the payment is credited to the

outstanding receivable. The billing system is able to produce reports on the number of days billed by cost center, but is currently unable to produce cost center specific revenue reports. This deficiency has been recognized and processes to produce the revenue reports have been incorporated in the design of the OMH Uniform Billing System (UBS) which is currently under implementation.[2]

In December 1981 OMH and DAAA signed a Memorandum of Agreement pertaining to the Alcoholism Treatment Centers which said:

> Current efforts of the Office of Mental Health to identify alcoholism specific billings and collections will be completed by the end of the current fiscal year (March 31, 1982).[3]

OMH did not carry out its agreement to identify alcoholism collections in 1982-83.

OMH provided the information that $85,409 had been collected for alcoholism patients from April 1, 1983 to May 30, 1983 from Medicaid, Medicare, and third parties. If projected to March 31, 1984 this would be approximately $512,454 collected for the full 1983-84 fiscal year. This compares to $2.8 million estimated in the 1983-84 Executive Budget. The $512,454 equals 2.6 percent of all costs in 1981-82, the latest year on which OMH could provide cost information. Since June 1982 the federal government has not made payment on claims for Medicaid eligible persons ages 21-64 because of differing interpretation of federal laws and regulations. OMH is negotiating with the federal government on this matter.

Chapter Summary

- Per patient day costs for rehabilitation at State alcoholism treatment centers in 1981-82 ranged from $54 at Rockland to $173 at South Beach. The larger centers had lower per patient day costs.

- The cost per stay of rehabilitation patients at State alcoholism treatment centers in 1981-82 ranged from $1,847 at Rockland to $8,167 at Bronx. These costs reflect differences in average length of stay and cost per patient day.

- The State alcoholism treatment centers employed 452 persons on June 29, 1983, below DAAA's goal of 477 persons. DAAA plans call for reassigning 21 beds and 16 employees from detoxification to rehabilitation at Pilgrim. However, the existing 79 rehabilitation beds at Central Islip (now Pilgrim) were only 53.5 percent occupied in 1982-83. The 21 increased rehabilitation beds at Pilgrim can not be justified based on the 53.5 percent occupancy rate.

- OMH did not carry out the Memorandum of Agreement with DAAA to identify collections on behalf of alcoholism patients in 1982-83.

- Based on two months collections from April 1, 1983 to May 30, 1983 of $85,409 projected to a full year, OMH will recover less than three percent of costs of operating the State alcoholism treatment centers in 1983-84.

FOOTNOTES

I Introduction

1. See Capital Area Community Health Plan, Alcoholism (Albany, N.Y., 1983) pp.1-6 and Milam, James R. and Ketcham, Katherine, Under the Influence, A Guide to Myths and Realities of Alcoholism (Seattle, Washington, 1981).
2. DAAA, Five Year Comprehensive Plan for Alcoholism Services in New York State, 1982 Update, p.18.
3. DAAA, Five Year Comprehensive Plan for Alcoholism Services in New York State, 1981 Update, p. 21.
4. Office of the State Comptroller, Division of Audits and Accounts, Report AL-ST-66-82, Financial Management Practices, Division of Alcoholism and Alcohol Abuse, May 9, 1983.
5. Mental Hygiene Law, Section 19.01.
6. Ibid, Section 19.07 (a) (9).
7. Ibid, Section 19.07 (a) (12).
8. Ibid, Section 41.01.
9. Ibid, Section 41.17 (a) (3) (4).
10. Chapter 978 of the Laws of 1977.
11. Mental Hygiene Law, Section 5.05 (b).
12. Ibid, Section 5.07.
13. DAAA, Five Year Comprehensive Plan for Alcoholism Services in New York State, 1982 Update, pp. 119-126.
14. Mental Hygiene Law, Section 19.10 (Chapter 595 of the Laws of 1983).
15. Public Health Law, Section 2803 (1) (f) (Chapter 595 of the Laws of 1983).

II. State Operated Treatment Program

1. DAAA, Policies and Procedures for State Operated Alcoholism Services--Service Areas for Alcoholism Treatment Centers, December 15, 1981, p. 1.
2. DAAA, Systemwide Program Plans for State Operated Alcoholism Services, December 1982, p. 3.
3. DAAA, Manhattan Alcoholism Treatment Center 1982-83 Annual Program Management Plan, p. 2.
4. DAAA, Policies and Procedures for State Operated Alcoholism Services--Admission and Inpatient Rehabilitation Treatment of Persons Under Age 18, April 7, 1980, p.2.
5. DAAA, Survey of ATCs Concerning Adolescent Admissions, Spring 1983.
6. DAAA, Systemwide Program Plans, p. 4.
7. Mental Hygiene Law, Section 1.01.
8. Mental Hygiene Law, Section 19.07 (a).
9. Mental Hygiene Law, Section 5.05 (b).
10. Joseph A. Califano, Jr., The 1982 Report on Drug Abuse and Alcoholism, June 1982, p. 49.
11. U.S. Department of Health and Human Services, National Institute on Drug Abuse, Drug Abuse Warning Network (DAWN), Series I, Number 1, Annual Data 1981, p.p., 22, 24, 41, 71, 83.
12. NYS Department of Mental Hygiene, InterOffice Coordinating Council, Report of the Task Force on Multi-Disabilities: A Plan for Services to Multi-Disabled Persons in the State of New York, January 1, 1979, p. 4.

13. DAAA, John L. Norris Alcoholism Treatment Center, Responses to LCER Questionnaire, June 21, 1983, p. 2.
14. NYS, Inter-Office Coordinating Council Committee on the Multiply Disabled, Services to the Multiply Disabled, An Annual Report to the Legislature, December 1981, p.p. 19-21.
15. Ibid., p.p. 19-21.
16. Ayerst Laboratories Inc., Patient Information Sheet, September 1979.
17. Ibid.
18. Richard D. McConchie, Ph.D., et. al., "Disulfiram-Induced De Novo Seizures in the Absence of Ethanol Challenge," unpublished article for the Journal of Studies on Alcohol.
19. Letter from Research Director, DAAA Manhattan Alcoholism Treatment Center to DAAA, July 29, 1983.
20. Letter from DAAA Coordinator of State Operated Alcoholism Services to LCER, August 23, 1983.
21. NYS Education Department, Office of Vocational Rehabilitation, "Cooperative Agreement Governing Joint Relationships and Activities of the NYS Department of Mental Hygiene, DAAA and the NYS Education Department, Office of Vocational Rehabilitation," November 1981, p. 3.
22. Ibid., p. 2.
23. NYS Education Department, Office of Vocational Rehabilitation, Vocational Rehabilitation Manual, April 1981, Section 1205, p. 3.
24. DAAA, C.K. Post Alcoholism Treatment Center, Response to LCER Questionnaire, July 19, 1983.
25. DAAA, Systemwide Program Plans, p. 46.
26. Ibid., p. 1.
27. Ibid., p. 9.
28. Ibid., p. 6.
29. Mental Hygiene Law, Section 5.07.
30. Ibid.
31. DAAA, Five-Year Comprehensive Plan for Alcoholism Services in New York State, December 1978, p. 13.
32. DAAA, Five-Year Comprehensive Plan for Alcoholism Services in New York State, 1982 Update, October 1, 1982, p. 43.
33. Ibid., p. 18.
34. DAAA, Five Year Comprehensive Plan for Alcoholism Services in New York State, 1981 Update, October 1, 1981, p. 65.
35. DAAA, 1982 Update, p. 37.
36. Ibid., p. 36.
37. Ibid., p. 93.
38. DAAA, Alcoholism Planning Analyst III, September 22, 1983. The seven counties are Albany, Bronx, Erie, Nassau, New York, Onondaga, and Westchester.
39. Letter from DAAA Coordinator of State Operated Alcoholism Services to LCER, August 26, 1983.
40. DAAA, Research Institute on Alcoholism. Outcome Study of Alcoholism Rehabilitation Units, November 1979, p. 60.
41. Stephen W. Voris, "Alcohol Treatment Outcome Evaluation: An Overview of Methodological Issues," American Journal of Drug and Alcohol Abuse 8 (4), 1981-82, p. 554.
42. DAAA, Bronx Alcoholism Treatment Center, Response to LCER Questionnaire, June 28, 1983.

III Monitoring

1. DAAA, Site Visit Protocol, March 19, 1982, pp. 1,5.
2. 14 NYCRR 84.
3. DAAA, Assistant Director, letter to LCER, July 13, 1983.

IV. Finances

1. These cost figures were provided by the Office of Mental Health. Under the Memorandum of Agreement signed by OMH and DAAA in December 1981 the two agencies were supposed to determine the full cost of operating the ATCs. LCER staff could find no indication that such a joint review was ever undertaken.
2. OMH, Finance Division, Office of Resource Development and Coordination, Director, August 26, 1983.
3. DAAA and OMH, Memorandum of Agreement Pertaining to the Alcoholism Treatment Centers, December 1981, p.6.

APPENDIX A

LIST OF INTERVIEWS AND CONTACTS

New York State
Division of Alcoholism and Alcohol Abuse

Central Office

Acting Director; Deputy Director for Comprehensive Program Operations; Coordinator of State Operated Alcoholism Treatment Services; Deputy Director, Administration; Assistant Director, Treatment and Rehabilitation; Assistant Director, Standards and Certification; Assistant Director, Local Services Planning; Assistant Director, Budget and Fiscal Management; Assistant Director, Bureau of Evaluation and Information Services; Alcoholism Program Assistant III; Associate Biostatistician; Alcoholism Program Specialist IV; Alcoholism Planning Analyst III.

Division Offices

Metropolitan District Director, New York City; Central, Northeastern and Mid-Hudson District Director; Northeastern Regional Director.

Research Institute on Alcoholism

Acting Director; Research Scientist I.

Alcoholism Treatment Centers

Bronx: Director, Psychologist II.

Creedmoor: Medical Director, Psychologist II, Psychiatric Social Worker I, Alcoholism Rehabilitation Assistant I, Nurse I.

Kingsboro: Director, Alcoholism Treatment Program, Kings County Addictive Diseases Hospital; Assistant Director, Alcoholism Treatment Program, Kings County Addictive Diseases Hospital.

Manhattan: Director, Psychologist I, Occupational Therapy Assistant II, Alcoholism Rehabilitation Assistant II (2).

Marcy: Medical Director, Psychiatric Social Worker II, Nurse II Psychiatric.

Middletown: Medical Director, Psychiatric Social Worker II, Nurse II Psychiatric.

John L. Norris (Rochester): Director, Psychiatric Social Worker II.

C.K. Post (Central Islip until June 1983, Pilgrim after June 1983): Director, Project Director, Psychiatric Social Worker II.

Rockland: Medical Director, Community Mental Health Nurse, Alcoholism Rehabilitation Assistant II.

St. Lawrence: Director, Psychiatric Social Worker Assistant III (2).

South Beach: Director, Psychologist II, Senior Stenographer.

Margaret A. Stutzman (Buffalo): Director, Nurse Administrator Psychiatric I, Psychiatric Social Worker II.

Dick Van Dyke (Willard): Director.

New York State
Office of Mental Health

Bureau of Reimbursement and Costing Services: Director, Principal Health Care Fiscal Analyst; Bureau of Statistical Analysis, Director; Office of Resource Development and Coordination, Director.

New York State
Office of Vocational Rehabilitation

Regional Director, Operations.

Community Agencies

Long Island

Brunswick House, Brunswick Hospital, Suffolk County: Executive Administrator.

Catholic Charities, Talbot House, Suffolk County: Director.

Nassau County Department of Drug and Alcohol Addiction: Commissioner, Deputy Commissioner, Director of Alcoholism Addiction Services.

Roosevelt Community Mental Health Center, Nassau County: Director, Outpatient Department.

Suffolk County Health Services Department: Director of Mental Health.

Manhattan

Bowery Residents Committee, Inc.: Director, Program Director of Emergency Care Services, Program Director of Social Rehabilitation.

Employment Program for Recovered Alcoholics (EPRA): Executive Director.

ENTER Alcoholism, Inc.: Program Director, Residence Manager, Treatment Director of Day Program.

Manhattan Bowery Corporation: Director, West Side Social Setting, Alcoholism Treatment Center.

New York City Department of Mental Health, Mental Retardation and Alcoholism Services: Director, Bureau of Alcoholism Services.

St. Luke's-Roosevelt Hospital: Medical Director, Trinity House; Administrator, Trinity House; Manager, Residential Treatment Unit.

Marcy and St. Lawrence Service Areas

Albany Citizens Council on Alcoholism: Executive Director.

Alcoholism Center of Rensselaer County: Director.

Confier Park (Schenectady): Executive Director.

Ellis Hospital Day Treatment (Schenectady): Director.

Montgomery County Alcoholism Services Program: Director.

The Next Step, Inc. (Albany): Alcoholism Rehabilitation Counselor.

Oneida County Department of Mental Health: Director, Alcoholism Services.

St. Peter's Alcoholism Rehabilitation Center (Albany): Manager, Assistant Manager.

Salvation Army (Albany): Director.

Saratoga County Alcoholism Services: Coordinator.

APPENDIX B

AGENCY RESPONSES

New York State Division of Alcoholism and Alcohol Abuse

New York State Office of Mental Health

New York State Education Department

Page numbers in the preliminary report differ from those in the final report. Thus, page numbers in the agency responses have been changed to conform to this published report.

STATE OF NEW YORK
DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE
194 WASHINGTON AVENUE, ALBANY, NEW YORK 12210

ROBERT A. ROSS
ACTING DIRECTOR

November 18, 1983

Mr. Sanford E. Russell
Director
State of New York
Legislative Commission
on Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Russell:

Thank you for the opportunity to comment upon your Preliminary and Confidential program audit of the State Alcoholism Treatment Centers. The Division's staff has prepared an analysis of the report in selected areas and it is enclosed. I wish to share some general comments.

Though the draft report does identify some areas requiring attention, it does not adequately reflect the major policy, program design, and management initiatives delineated in the Division's Systemwide Program Plans for State Operated Alcoholism Services, December 1982. The Division's implementation of the comprehensive changes described in these plans are not sufficiently acknowledged. An example of this is the report's conclusion, based upon only three cited issues, that there should be generally more central control than that called for in the Systemwide Program Plans. In this connection, some of the findings in the executive summary exceeds the factual presentation in the rest of the report. The Systemwide Program Plans have been and are being implemented centrally. However, the trade-offs required between Central Office and Alcohol Treatment Center (ATC) initiatives are not noted in the report. Each ATC is part of a local system of services, each of which varies greatly; thus, the ATC must tailor its activities accordingly. As stated in the Systemwide Program Plans, the Division tries to balance these two requirements: "A systems approach has been taken with the purpose of identifying key elements of the SOAS. The approach requires control and continuous reviews centrally, to enhance the efficiency of the system while providing each of the thirteen Alcoholism Treatment Centers (ATCs) with sufficient flexibility to effectively provide alcohol abuse treatment within the unique dimensions of its setting."

The nature of alcoholism as a disease and the related issues of the continuum of treatment services and the measurement of effectiveness are not accurately reflected in the report. Thus, several of the statements indicating that there may be significant differences among ATC directors and

Central Office staff are misleading. Of particular concern are draft report conclusions regarding patient abstinence, relapses, the continuum of care and the roles of the ATCs as part of this continuum the goals of treatment and the measurement of patient outcome. The Division's analysis of the draft audit report is that some of the conclusions in the above mentioned areas are based on insufficient data and some serious misunderstandings about the realistic expectations of alcoholism rehabilitation services. The draft report's contention that so called 'total abstinence indefinitely' should be the only criterion of ATC effectiveness is not accurate or realistic. The Division subscribes to the philosophy that abstinence is the goal of treatment for the alcoholic in the alcoholism service system, however, an ATC is not the whole system. Its specific role in the system is to provide the inpatient rehabilitation component for those who need it.

The audit was carried out during a period when the changes, substantial in nature, called for in the Systemwide Program Plans were being implemented. The impact of this transitional situation, as well as of the actual or pending relocations of some of the ATCs, on several of the facts and findings of the report was not acknowledged. Examples of note are the utilization rates at the Charles K. Post and Rockland ATCs.

The draft report either states or implies that each ATC should go beyond the generally accepted practices regarding follow-up, that is, each should continuously carry out outcome research of patients after discharge. This expectation fails to mention or take into account the state-of-the-art in this area of research or the significant additional costs that would be needed to meet the methodological requirements. However, another Research Institute on Alcoholism study is being considered as suggested by the report.

With respect to fiscal and unit cost data, the Division is concerned that the data on revenue and costs, as presented in the draft report can lead to erroneous conclusions about the revenue capability and comparative cost of ATCs. Data for this Section was independently submitted by the Office of Mental Health, which will provide a proposed response to you under separate cover. The costing methodology utilized by OMH is consistent with the State's priority on maximizing reimbursement from federal sources, though collections indicated in the draft report are far below the Executive Budget and Appropriation projection of $2.8 million. Of particular concern is the insufficient level of recognition of the fact that the federal government has discontinued payments of month of admission/month of discharge medicaid reimbursement for 22-64 year olds.

Finally, I wish to take note of the references in the report to the Division's letter of October 27, 1983. The contents of the letter were included in prior verbal communications, as well as several Division documents made available to the audit team from the beginning of and throughout the audit.

Again, thank you for the opportunity to react to the report. If your staff would like to discuss our analysis, they may contact Phillip Dawes, Deputy Director, at 473-5072.

Sincerely,

Robert A. Ross
Acting Director

NEW YORK STATE DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE

Commments on the Preliminary and Confidential Program Audit of the Legislative Commission on Expenditure Review on State Alcoholism Treatment Centers

The comments provided below fall into six general areas, organized according to topic:

I. Nature of Alcoholism Services
II. Follow-Up
III. Multiply Disabled
IV. Certification Standards
V. Impact of Planned Changes as Reflected in Program Audit
VI. Costs and Collections
VII. Central Policy Guidance

References to the location in the report are given for each comment to assist the reader in following the agency review.

I. The Nature of Alcoholism Services

The role of the Alcoholism Treatment Centers (ATCs). Statements are made on pages S-1, S-2 and 19, indicating that the role of the ATCs as reported by facility Directors is to rehabilitate alcoholics "and make them totally abstinent..."Regrettably, these statements have taken wholly out of context the responses of facility Directors to a question on the role of treatment.

The ATC Directors were asked the following question by LCER audit staff: "Is the goal of treatment total abstinence or partial abstinence or does it vary by patient?"

First, this question does not inquire about the goal or role of the ATC which is but one component of the full continuum of the alcoholism service system, but instead refers to the 'goal of treatment', i.e. the full system of services. The report's conclusion linking and limiting the responses of facility Directors to the 'role of the 13 ATCs is erroneous and inappropriate.

Second, the question inquiries whether the treatment goal is considered to be "total abstinence or partial abstinence." The categorical and appropriate response of all ATC Directors was that total abstinence rather than partial abstinence is the goal of the alcoholism treatment continuum of care of which the ATCs are only one component. Unfortunately, the report improperly interpreted this response to mean that the treatment component provided by the ATCs is sufficient "to make alcoholics abstinent." As pointed out not only in the Division's October 27, 1983 letter to LCER staff but in the numerous other documents and reports furnished by central and facility staff during the audit, the role of the ATCs is to provide inpatient

rehabilitation components of the continuum of care offering alcoholics the foundations for long term sobriety. Three ATCs also provide small non-inpatient rehabilitation components which are being transitioned to local auspices.

Effectiveness of Treatment. As noted earlier and further referenced on pages S-5, 19 and 38 the report makes a direct connection between the effectiveness of ATC treatment and patient abstinence "indefinitely" from alcohol. The strong implication is made that if patient returns to drinking after discharge from the ATC, then the ATC has not been effective. This conclusion fails to acknowledge the state of the art in alcoholism treatment services where relapses are to be expected for many alcoholics, especially the clientele served in the ATCs which consists mostly of patients who are in the advanced stages of alcoholism with chronic manifestations of the disease. This reality is clearly delineated in the Systemwide Program Plans for SOAS. Abstinence is, of course, the ultimate goal of the service system but the number of treatment episodes required before this is achieved varies. The principal goal of the ATCs is to furnish alcoholics with intensive rehabilitation which forms the base for ongoing treatment and long term sobriety. The report's indication that a single provider, the State Operated ATC is expected to achieve "abstinence indefinitely" for all patients is unrealistic, and the conclusions on program effectiveness based on that expectation are therefore flawed.

Use of Disulfiram - The report states on pages S-2, 20 and 21 that there is no overall policy on the use of the medication, disulfiram. The Division's expectation has been and continues to be that the use of disulfiram, as with all other drugs, is based upon a determination by a facility physician in accordance with medical practices. This is inaccurate. ATC Medical Doctors prescribe disulfiram and other drugs after reviewing the medical history and the presenting condition of the patient. As with other medications disulfiram is administered only when medically indicated and in close compliance with the guidelines of the drug manufacturer. The Manhattan ATC study referenced in the draft report concluded that further study regarding the use of disulfiram may be appropriate. The Division is continuing its review of the utilization of this medication.

II. Follow-Up

The report on page S-3 indicates that only the Bronx and St. Lawrence ATCs had adequate follow-up efforts, and further states on page S-6 that there is no policy on follow-up for the ATCs. These statements do not logically follow the facts described in the Inventory of Evaluation and Research Studies for SOAS, June 1983 which was provided during the audit. This inventory found that the thirteen ATCs have recently completed, are conducting or are initiating many individual evaluation and quality assurance studies. Out of these, nine ATCs are specifically dealing with follow-up at this time. It should be noted that a systemwide follow-up mechanism has been initiated and is being implemented with the installation of computer terminals at each facility.

III. Treatment of Multiply Disabled Patients

Referring to the Mental Hygiene Law's section on multiply disabled, it is indicated on page S-2 that ATCs do not treat alcoholics who are either addicted to "hard drugs" or are psychotic. The conclusion is then made that the ATCs do not "sufficiently conform" to legislation on treatment of the multiply disabled. This conclusion appears to be overreaching to find fault, and fails to acknowledge the differences in mission, clientele, program designs and resources among the mental hygiene agencies. The majority of alcoholics treated in State operated ATCs do indeed have some degree of concurrent psychiatric or other substance abuse problems. The ATC program methodologies, treatment formats and clinical staffing are specifically designed to treat more difficult patients with these additional conditions. However, the ATCs are not structured or equipped to treat hard drug abusers or the psychotic but do refer such individuals to appropriate services. To require them to do so would call for a complete change in the nature of services and would result in many alcoholics needing inpatient rehabilitation not receiving appropriate care.

IV. Certification Standards

The report indicates that the Division does not certify its own facilities (pages S-4 and 45). On the one hand the report concedes that the certification requirements of the Mental Hygiene Law specifically do not apply to State operated facilities, but goes on to imply that this should be done. It is the position of this agency, similar to that of the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities that such self certification of state psychiatric and developmental centers is unnecessary and inappropriate. Rather, all the State ATCs are reviewed by and have received full accreditation from the Joint Commission on Accreditation of Hospitals, an outside nationally recognized authority. In addition, however, the proposed alcoholism inpatient standards established by the Division have been fully assimilated into the Division's Systemwide Program Plans for State Operated Alcoholism Services.

V. Impact of Planned Changes as Reflected in Program Audit

It is unfortunate that several statements on projected service levels and other plans of the DAAA have been taken out of context and fail to reflect the reality of the transitional status of the State ATC system as the Systemwide Program Plans are being implemented.

- In 1982-83 the SOAS system achieved an 11% increase in patient admissions over the previous year; the report describes on pages 28 and 29 admission levels as being 5% less than the agency's projection.

- The Rockland ATC transitioned a portion of the detoxification beds to increase its inpatient rehabilitation capacity, consistent with both Division plans and the increase in local detoxification beds. The report's conclusion on page 65 that the Rockland ATC operated at 115% of capacity is incorrect.

- The CK Post ATC underwent a move to a new Psychiatric Center on Long Island. Also this facility was disproportionately affected by its large number of early retirements and the simultaneous hiring freeze on state employment during the period referenced. These factors were not acknowledged by the draft report. They had a direct and expected reduction in the facility's service levels. The report on pages S-3, 11 and 27 refers to the reduced service statistics of the ATC but fails to explain its legitimate causes.

- The Division has achieved a large scale transition of non-inpatient rehabilitation services to community auspices along with reduction in staffing levels. The report does not mention this accomplishment. Rather, it emphasizes that all of the remaining detoxification services had not been transferred as of August 1983 without acknowledging that this did not conflict with the Division's plans.

- With respect to selected factual inaccuracies, the bed capacities, as reflected in the Systemwide Program Plans, prior to the further transition of non-inpatient rehabilitation services in 1983-84 are: 498 beds for inpatient rehabilitation, 43 beds for detoxification and 19 independent living beds. The Division again requests that the inaccurate figures on pages S-1, S-2, S-3 and S-4 be changed. As planned, the inpatient rehabilitation capacity of the system is being increased to 517 by March 31, 1984 with the transition of detoxification services to local auspices and the simultaneous increase in inpatient rehabilitation capacity.

VI. Costs/Collections

Chapter IV of the report covers some of the financial aspects of the State's operation of the ATCs. As noted in the cover letter of Mr. Robert A. Ross, Acting Director, the data utilized in the report are not accurate and require refinement in cooperation with the Office of Mental Health. For example, two identical sized units, Marcy and Manhattan ATCs show an $800,000 or 50% difference in operating costs which are inexplainable and inconsistent with Division appropriation data.

VII. Central Policy Guidance

The draft report indicates (page S-6) that the Division should provide more central control. Reference should be made to the cover letter for the Division's approach to this issue. The draft audit report does not acknowledge the extent and depth of the central control already being implemented in accordance with the Systemwide Program Plans. Central policy and management direction have been established with respect to the following:

- Nature of ATC Treatment Services
- Treatment Modalities for SOAS Inpatient Rehabilitation
- Goals of Treatment at the ATC's
- Composition of ATC's Target Population
- Continuum of Treatment
- ATC Service Networking
- Service Areas of Facilities
- Components of Service for each ATC
- Capacities of each ATC
- Projected Service Level Targets (admissions, length of stay, occupancy rates)
- Model Staffing Plans
- Management Information Systems
- Monitoring and Technical Assistance Site Review
- ATC Annual Program Management Plans
- Transfer of Non-Inpatient Rehabilitation Components

The draft audit report makes reference to many of these policy areas in the body of the report and the audit team was provided with documentation of the Division's activities in these areas. The report even acknowledges their successful implementation (e.g. conduct of ATC Site reviews, page 45; staffing requirements, page 50; increase in service levels, pages 26 and 27; provision of pre-JCAH accreditation surveys, page 44). There is marked inconsistency between the body of the report and the statement regarding central guidance on page S-6 of the Summary and Conclusion section.

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

STEVEN E. KATZ, M.D., Commissioner

William F. Morris
Executive Deputy Commissioner

November 21, 1983

Mr. Sanford E. Russell
Director
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Russell:

As requested in your letter of September 26, 1983, we are forwarding our comments on the "State Alcoholism Treatment Centers" draft audit. Issues that were raised in the report that invclve the Office of Mental Health (OMH) include:

1. Based on two month's collections from April 1, 1983 to May 30, 1983 of $85,409 projected to a full year, OMH will recover less than three percent of costs of operating the State Alcoholism Treatment Centers in 1983-84.

Response

The most recent information available indicates that OMH has collections totaling $159,462.71 through June 30, 1983. The statement that OMH will only collect reimbursement for a small portion of these costs is factually correct. This is due in large part to the following factors.

- the nature of the patients served in these settings results in very low level of individuals eligible for Medicare or Third Party Health Insurance coverage, and very few patients with personal financial ability to pay all or a part of the cost of their services.

- the federal government has discontinued payment for month of admission/month of discharge Medicaid reimbursement for 22-64 year olds (as stated in the report).

- the lack of accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) at Manhattan Psychiatric Center has precluded any Medicare Part A or Medicaid reimbursement for services rendered at that site (as stated in the report). However, Manhattan Psychiatric Center was recently accredited by JCAH and OMH is applying for reinstatement into the Medicare and Medicaid programs.

2. OMH did not carry out the Memorandum of Agreement with DAAA to identify collections on behalf of alcoholism patients in 1982-83.

Response

OMH was unable to carry out the provisions of the agreement relating to collections in 1982-83 due to serious limitations in the automated billing system at that time. OMH has partially completed the implementation of the new Uniform Billing System (UBS) since the beginning of the new 1982-83 fiscal year.

The implementation of Medicare and Medicaid into UBS and the implementation of a carefully controlled clerical tabulation has allowed OMH to provide monthly reports of alcoholism receipts since April 1, 1983.

3. Since July 15, 1981 the federal government has not paid any Medicaid or Medicare claims filed by OMH for either psychiatric or alcoholic patients at Manhattan Psychiatric Center. While the Manhattan Alcoholism Treatment Center has JCAH accreditation, the Manhattan Psychiatric Center in which the ATC is housed, has lost its JCAH accreditation. Both accreditations are required for the State to be paid by the federal government for Medicaid and Medicare patients.

Response

The Office of Mental Health has just received notification that JCAH accreditation will be granted to the Manhattan Psychiatric Center. OMH is initiating the steps necessary for reinstatement into the Medicaid and Medicare programs. Once accomplished, billing at Manhattan, including billing for the alcoholism treatment center, will be reinstated.

If you require any further information, please contact Joanne K. Hilferty, Deputy Commissioner, Quality Assurance and Finance Division. She may be reached at 518-473-3861.

Sincerely,

William F. Morris
Executive Deputy Commissioner

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE OF THE PRESIDENT OF THE UNIVERSITY
AND COMMISSIONER OF EDUCATION
ALBANY, NEW YORK 12234

October 18, 1983

Dear Mr. Russell:

I wish to thank you for the opportunity to comment on the program audit, "State Alcoholism Treatment Centers."

There are several comments made within the report which indicate a dissatisfaction by the ATC's in regard to the receipt of services from the Office of Vocational Rehabilitation. It should be noted that the statewide agreement was developed in April 1981 to assist in the provision of OVR services primarily through the community treatment programs. In the initial discussions with the administration of the Division of Alcoholism and Alcohol Abuse it was determined that the ATC's would not, in all likelihood, be providing many referrals to OVR because of the instability of the clients at that point in their recovery. The Office of Vocational Rehabilitation shared with DAAA the draft policy containing the language relative to the six month abstinence period prior to implementation of the agreement. The DAAA approved the policy statement without making any comment on the six month abstinence provision.

The OVR found that immediately after implementation of the policy there was a drop in the number of alcoholism referrals. However, since then the number of referrals has returned to pre-implementation levels. More importantly, since implementation of this policy, the number of those returned to employment has increased by over 50%.

The statewide cooperative agreement has a clause for a periodic review and assessment of the effectiveness of the agreement. To date, the DAAA has not indicated to OVR that problems had arisen, nor has there been a request for a review. The OVR is quite willing to meet and work toward solutions of any difficulties that would interfere with the provision of services to appropriate clients.

Sincerely,

Gordon M. Ambach

Mr. Sanford E. Russell
Director
Legislative Commission
on Expenditure Review
111 Washington Avenue
Albany, NY 12210

PROGRAM AUDITS* OF THE
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DOT Real Estate Program, April 15, 1976.

Solid Waste Management in New York State, May 20, 1976.**

Boards of Cooperative Educational Services Programs, June 28, 1976.**

Boards of Cooperative Educational Services Finances, June 30, 1976.**

Workmen's Compensation Program for State Employees, July 30, 1976.**

Public Pension Fund Regulation, October 29, 1976.

Computers in New York State Government, December 1, 1976.**

Health Planning in New York State, January 3, 1977.**

The Optional Service Charge Law, March 11, 1977.

Immunization of Children, May 27, 1977.

State Parks and Recreation Program, October 11, 1977.

State Travel Costs, December 15, 1977.**

Venereal Disease Control, December 16, 1977.

State Environmental Permits, December 19, 1977.

Pupil Transportation Programs, January 30, 1978.**

Housing Maintenance Code Enforcement in New York City, March 31, 1978.

Vacation Credit Exchange, June 16, 1978.

Adirondack Park Planning and Regulation, July 31, 1978.

School Food Programs, August 7, 1978.

SUNY Developing and Nontraditional Colleges, September 26, 1978.

Newborn Metabolic Screening Program, October 31, 1978.

Fiscal Effect of State School Mandates, December 20, 1978.

School District Budget Voting and Contingency Budgeting, December 26, 1978.

State Aid for Operating Sewage Treatment Plants, April 16, 1979.

Crime Victims Compensation Program, April 23, 1979.

Drinking Driver Program, May 15, 1979.

Unemployment Insurance for State Employees, July 20, 1979.

Work Programs for Welfare Recipients, August 3, 1979.

CETA Programs in New York State, August 24, 1979.

Parole Resource Centers Program *(Research Report)*, August 31, 1979.

Local Government Use of State Contracts, October 15, 1979.

Use of State Adult Psychiatric Centers, February 29, 1980.

National Guard Strength and Armories, March 17, 1980.

School District Committees on the Handicapped, April 15, 1980.

Delinquency Prevention and Youth Development Programs, May 2, 1980.

Energy Use in State Facilities, June 11, 1980.

Occupational Education in Secondary Schools, July 8, 1980.

Use of State Developmental Centers, November 6, 1980.

Energy Research and Development Programs, December 24, 1980.

State Subsidized Low Rent Public Housing, December 31, 1980.

Taxpayer Services Program, March 9, 1981.

Title XX Social Services, March 13, 1981.**

State Prison Inmate Health Services, June 19, 1981.

Runaway and Homeless Youth, July 15, 1981.

State Mandates to Counties *(Research Report)*, August 14, 1981.

Control of the State Telephone System, August 21, 1981.

Hospital and Nursing Homes Management Fund, October 5, 1981.

Methadone Program, December 21, 1981.

Regulation of Automotive Repair Shops, December 24, 1981.

School District Cash Management, December 29, 1981.

Pupils With Special Educational Needs, April 30, 1982.**

State Division of Probation Programs, June 10, 1982.

State Physician Shortage-Maldistribution Programs, July 16, 1982.

Commission on Cable Television, September 15, 1982.

Management of Youth Rehabilitation Programs, October 29, 1982.

Impact of Youth Rehabilitation Programs *(Research Report)*, October 29, 1982.

Council on the Arts Application Review and Funding, November 29, 1982.

The Weatherization Assistance Program, December 6, 1982.

SUNY Hospitals, February 28, 1983.

Dormitory Vandalism on SUNY Campuses, March 24, 1983.

Procurement of Consulting Services *(Memorandum Report)*, March 31, 1983.

Processing of Human Rights Cases, April 25, 1983.

Contractual Social Services Training Programs, June 3, 1983.

Comparative Resident and Non-Resident Tuitions, Enrollments and Policies in the Fifty States *(Memorandum Report)*, June 7, 1983.

State Operated Ski Centers, September 30, 1983.

Mental Health Community Support System, October 28, 1983.

Education of Children Under State Care or Custody, November 30, 1983.

State Insurance Fund, December 9, 1983.

State Alcoholism Treatment Centers, December 14, 1983

* Excludes 45 reports printed 1971 through 1975. A list of these publications may be obtained by request of the Commission.

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